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## **Personal Responsibility for Health; Should we Bear the Costs of our Risky Health Affecting Choices?**

Hooper, Carwyn

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**Author:** Carwyn Hooper

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**Personal Responsibility for Health;  
Should we Bear the Costs of our  
Risky Health Affecting Choices?**

**Dr. Carwyn Rhys Hooper**

**Thesis submitted for the degree of Doctor of Philosophy**

## **DEDICATION**

This thesis is dedicated to my father, Andrew Hooper, who will never read what I have written. He was, like me, simultaneously a lecturer and a PhD student. However, he tragically died before submitting his own thesis when I was a child. I know that my own academic achievements cannot redeem the suffering and loss that my family experienced when my father died, but I feel that the completion of my own PhD does allow me to close a chapter in my life and, in a way, his. I also hope that my father would have been proud of my achievements had he lived to see them. Thank you, Dad, for all that you have given me. I will remember you always.

## **ACKNOWLEDGMENTS**

It is impossible to thank, by name, everyone who has helped me to complete this thesis. However, I would like to take this opportunity to thank those who have played the most prominent roles in this particular academic endeavour.

Firstly, I would like to thank my father, Andrew, who inspired me to become an academic. Secondly, I would like to thank Ffion and Mari for all the moral and emotional support they have given me throughout this latest academic venture.

Thirdly, I would like to thank Claudia for keeping me sane and motivated through all those long days and nights when I had to forgo regular life to work on my thesis.

Fourthly, I would like to extend a big thank you to my supervisors, Leif and Andrea.

Without their invaluable advice and intellectual assistance this thesis would still be mired in the ground. Fifthly, I would like to thank Heather, Len and Jo, for giving me the confidence to apply for a PhD in the first place. Sixthly, I would like to thank Deborah, John, Peter, Rehana, Jeremy, Guy, Ciar, Catrin, Rhiannon and Badr for their endless stream of advice, encouragement and general bonhomie over the last few years. Seventhly, I would like to thank my employer, St George's, University of London, for generously funding my research and allowing me to take regular study leave from my job as a lecturer to work on my thesis.

I am not sure of the truth of many things in life, but one thing I do know for sure is that this thesis would never have been written without the support that I have received from all the people mentioned above and many more people besides. Thank you all for your help, friendship and wisdom.

## **ABSTRACT**

What role, if any, the concept of personal responsibility for health should play in health policy is a burning question. Human beings have long known that their behaviour can cause ill-health, but it is only in the last century that we have come to understand that our behaviour is causally responsible for a substantial amount of the global burden of disease. Partly as a result of these new findings politicians have started to advocate “cost bearing” policies which require people who are responsible for their ill-health to bear some of the costs of their risky health affecting choices.

In this respect, policy makers and other stakeholders have stolen a march on philosophers because relatively little work has hitherto been carried out by these academics to determine whether cost bearing health policies are normatively justifiable and practically feasible. As such, the primary goals of my thesis will be to develop a framework for analysing these questions and to provide some substantive answers of my own.

The main conclusions that I will draw in thesis is that some forms of cost bearing policies – namely, “risk tax” and “risk insurance” policies – are both practically feasible and normatively reasonable and that these policies can be defended by at least five different normative arguments – including a theory of justice known as “luckist” luck egalitarianism. During the course of my thesis I will also defend the supplemental claims that ill-health is, causally speaking, very much in our own hands and that most people are substantively morally responsible for their risky health affecting choices.

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## Chapter 1

### Introduction

*“The fault, dear Brutus, is not in our stars, but in ourselves.”*

– William Shakespeare

#### 1.0 Personal responsibility for health and cost bearing

Should smokers bear the costs of their habit? Should sky divers be forced to purchase compulsory health insurance? Should people who contract sexually transmitted diseases be denied access to health care? Should people who eat too much saturated fat pay a “fat tax”? Should fire fighters, policemen and health care professionals pay for their treatment if they suffer injuries whilst on duty? Should patients waiting for liver transplants be given lower priority if they are suffering from alcoholic liver cirrhosis?

Philosophers, physicians and politicians are increasingly asking these kinds of questions and many policy makers have already put policies in place which require people who are “personally responsible” for their ill-health to bear some kind of cost. Germany has been in the vanguard in terms of implementing such policies, but many other countries have now followed suit (Schmidt 2009c). For example, the Danish government recently introduced legislation which requires people who purchase food with high levels of saturated fat to pay what has been dubbed a “fat tax” (Abend 2011). Successive British governments, meanwhile, have mooted the possibility of doing the same and it seems very likely that some kind of responsibility-based cost

bearing policies will be adopted in the UK in the near future. Indeed, about 10% of Primary Care Trusts in the UK have already put in place policies which deny obese patients access to hip and knee replacements unless they lose weight (Schmidt 2007c; Civanar and Arda 2008).

Importantly, there is also growing evidence that a significant number of health care professionals, patients and members of the lay public support the imposition of cost bearing policies (Neuberger et al. 1998; Richardson et al 2002). It is not yet clear precisely how many people support such policies. Nor can we be sure which types of cost bearing policies people prefer or why people wish to have such policies implemented. However, there is clearly a growing democratic mandate for such policies in many developed world countries.

In this thesis my primary goals will be to provide a framework for answering the question of whether cost bearing policies are normatively reasonable and practically feasible and to provide substantive answers of my own to these questions. In the process, however, I will draw a total of seven conclusions.

Firstly, a significant number of lay-people and health care professionals support the imposition of cost bearing policies. Secondly, human behaviour plays a substantive causal role in the aetiology of many common diseases which contribute significantly to the global burden of disease. Thirdly, a substantial number of people are substantively morally responsible for their risky health affecting behaviours. Fourthly, five different normative arguments converge together to defend the claim that people who are morally responsible for their ill-health should bear some of the costs of at

least some risky health affecting choices.<sup>1</sup> Fifthly, of these five normative arguments, the “luckist” version of the luck egalitarian argument is the most normatively robust. Sixthly, people can be made to bear costs through the adoption of at least five different health care policies.<sup>2</sup> Seventhly, the only responsibility-sensitive policies which are independently justifiable and can also be defended by all five of the normative arguments mentioned above are the “risk tax” and “risk insurance” policies.

### **1.1 Why should we care about personal responsibility for health?**

The importance of the concept of personal responsibility for health has waxed and waned for over two millennia. As a consequence, it is reasonable to ask whether and, if so, why there is an urgent need to address the issue of responsibility-based cost bearing policies. There are a plethora of reasons, but the following four best explain why this is so.

The first reason has to do with the fact that there is growing evidence to suggest that human behaviour causes a significant proportion of the global burden of disease and that this situation is getting rapidly worse.<sup>3</sup> I will discuss this specific claim in much more depth in chapter 4, but at this stage it will suffice to note that 6 of the 10 most

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<sup>1</sup> The five normative arguments are the “moralistic-desert”, “expected consequences”, “rights-harm”, “luck egalitarian” and “utilitarian” arguments.

<sup>2</sup> The five cost bearing policies that I will discuss are the “denial of access”, “payment”, “lower priority”, “risk tax” and “risk insurance” policies.

<sup>3</sup> As Wikler (2002) pithily puts it: *“in many cases, illness is not something that just happens to a person... We are more likely to remain healthy if we take care of ourselves. People who live prudently tend to live longer and avoid disability”*.

common causes of death worldwide are now thought to be partially caused by human behaviour and many of the diseases that cause the greatest burden of disease (e.g. obesity, cardiovascular diseases and type 2 diabetes) are now known to be directly linked to lifestyle choices (Resnik 2007; Feiring 2008; World Health Organization 2008). Moreover, all of these “lifestyle” diseases are becoming more prevalent in both developed and developing countries and many commentators have argued that a massive health-related crisis looms for citizens of the 21<sup>st</sup> and 22<sup>nd</sup> centuries as a direct result of the increase in risky health affecting behaviour that seems to be occurring worldwide (Cappelen and Norheim 2005).

The second reason is because a substantial and growing number of citizens claim that at least some patients should bear at least some of the costs of at least some of their risky health affecting behaviours. I will discuss the evidence for this claim in chapter 3, but for now I will simply note that a number of surveys and studies have demonstrated that a significant number of patients, health care professionals and lay-people believe that patients who engage in certain kinds of risky behaviours should bear some kind of cost (Ubel 1999; Richards et al 2003; Wittenberg and Fischhoff 2003). This is important because this data suggests that there is a democratic mandate, if not a democratic imperative, to implement such policies.

The third reason is because the cost of providing health care is rising at an almost exponential rate. When the NHS was first launched in 1948 it had a budget of £437 million (about £9 billion in terms of 2011 prices) but by 2011 the NHS budget had risen to £106 billion (National Health Service 2011a). In the USA the relative cost of healthcare has increased at an even more remarkable pace and it has recently been

estimated that health spending in the USA now accounts for around 18% of GDP (i.e. around \$2 trillion) (World Bank 2012a). In fact, Americans now spend about \$75 billion on smoking related medical expenses, \$75 billion on obesity, \$13 billion on HIV/AIDS and \$34.5 on alcoholism and drug addiction (Resnik 2007).

These price rises are important from the perspective of the responsibility for health debate because governments are actively looking at ways of displacing the cost of providing health care directly on to the consumer-citizen and a number of policy makers have realised that cost bearing policies can achieve this goal in a rather neat way (Cappelen and Norheim 2006; Mello 2008). Resnik (2007), for example, argues that the primary driving force behind the increased political focus on the concept of personal responsibility for health is the fact that costs are increasing at the same time as financial deficits are ballooning. He also argues that, from the perspective of developed world governments, *“it makes economic and medical sense to hold individuals morally responsible for their health-related choices”* (Ibid, p 444).

Just because increases in health care costs can be displaced on to citizens does not mean that they should be. Nevertheless, the dire nature of the current financial situation does mean that there is an especially pressing need to analyse and assess the claim that cost bearing responsibility for health policies are normatively legitimate. For it is only when we have done this that we can determine whether such policies can legitimately be used to help resolve the financial problems facing heavily indebted governments.

The fourth reason is because policy makers, politicians, insurance companies, health care professionals and many other stakeholders have effectively stolen a march on philosophers and bioethicists by both deploying the language of personal responsibility for health in day to day discourse and by implementing a range of cost bearing policies *before* these policies have been properly scrutinized.

It would be false to assert that these issues have not received any philosophical or ethical attention. The likes of Wikler (1978), Veatch (1980), Feiring (2008), Schmidt (2008) and Segall (2010), for example, have published numerous articles about the meaning and importance of the concept of personal responsibility for health and a number of philosophers, including Aristotle (1984), Hume (1987), Strawson (1962), Frankfurt (1969) and Fischer (1994) have contributed a great deal to the fundamental debates about the meaning and existence of causal, moral and consequential responsibility. However, there is still a dearth of academic monographs dealing exclusively with the issue of personal responsibility for health let alone with the specific sub-issue of cost bearing policies.

Consequently, much work still needs to be done to analyse the concept of responsibility and to address the question of whether cost bearing policies are justifiable and this work needs to happen urgently because millions of people are already being affected by these policies and millions more are likely to be affected in the near future.



## 1.2. Conceptual analysis and the multiple meanings of “responsibility for health”

The assertion that individuals are responsible for their health is uttered by a wide array of actors, in a wide array of different contexts, and with a wide variety of different intentions. To make matters worse, those who make use of the phrase “responsibility for health” rarely specify exactly what they mean when they use it. Indeed, Reiser (1985) argues that *“responsibility for health is in the eye of the beholder, whose vision is filtered through the prism of existing values”*.

This conceptual confusion is not, perhaps, surprising given that the concept of responsibility is such *“a richly ambiguous and complex concept”* and given that responsibility can signify very different things depending on the context in which the concept is used (Agich 1982). Hart (1968) even invented a short story to highlight the complexity of the concept and it is worth quoting this story in full because it neatly demonstrates how slippery the concept of responsibility really is:

*“As captain of the ship, X was responsible for the safety of the passengers and crew. But on his last voyage he got drunk every night and was responsible for the loss of his ship with all aboard. It was rumoured that he was insane, but the doctors considered that he was responsible for his actions. Throughout the voyage he behaved quite irresponsibly, and various incidents in his career showed that he was not a responsible person. He always maintained that the exceptional winter storms were responsible for the loss of the ship, but in the legal proceedings brought against him he was found criminally responsible for his negligent conduct, and in a separate civil proceedings he was held*

*legally responsible for the loss of life and property. He is still alive and he is morally responsible for the death of many women and children” (Ibid, p211).*

Unfortunately, the ambiguities that abound about the use and meaning of the concept of responsibility have led to a great deal of confusion in the everyday discourse of physicians, patients and policy makers and in the biomedical, bioethical and philosophical literature too. Consequently, before I delve any further into the issues that I wish to address in this thesis I will provide a brief conceptual analysis of the concept of responsibility for health and I will also clarify the meanings of the various technical terms that I will make use of in this thesis.

### **1.2.1 Causal, moral and consequential responsibility: the key distinctions**

The most important distinctions that I will draw in this thesis are the distinctions between causal, moral and consequential responsibility. That there are distinctions between these three concepts of responsibility will seem self-evident to many. Yet it is surprising how often people conflate these concepts. There is also a tendency to simply assume that if a patient is causally responsible for their ill health it necessarily follows that he or she must also be morally and consequentially responsible too (Yoder 2002; Cappelen and Norheim 2005). Of course, one might believe that causal responsibility is sufficient for moral and consequential responsibility, but this proposition needs to be argued for rather than assumed.

Given how common it is for these three concepts to be confused I will now spend some time analysing each concept in turn. Before I do so, however, I wish to make a

point about the terminology that is used by philosophers when discussing the concept of responsibility. This is necessary because different philosophers use different terms to describe a range of responsibility-concepts. For example, Scanlon (1998) draws distinctions between what he calls “*attributive*” and “*substantive*” responsibility in his analysis of the concept of moral responsibility, whilst Zimmerman (1988) prefers the terms “*appraisability*” and “*liability*” and Watson (2004) prefers “*attributability*” and “*accountability*”.<sup>4</sup> Knight and Stemplowska (2011), on the other hand, tend use the terms “*agent responsibility*” and “*consequential responsibility*”, whilst Dworkin (1981) uses the language of “*culpability*” and “*liability*”.

The trouble with this divergent terminology, aside from the confusion that it naturally engenders, is that none of the concepts as they are described and defined by the philosophers in question map directly onto each other. Nor, for that matter, do they map onto the more “traditional” concepts of causal and moral responsibility. For example, Dworkin’s concept of liability-responsibility and Scanlon’s concept of substantive-responsibility are clearly related, but they are not identical either.

This lack of consensus about which terms and concepts should be used in discussing responsibility leaves me with something of a quandary regarding the terminology that I should use in this thesis. However, having given the matter some thought, I have decided to stick to the concepts of causal, moral and consequential responsibility. This is primarily because bioethicists, health care professionals and policy makers tend to use the language of causal, moral and consequential responsibility when discussing personal responsibility for health.

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<sup>4</sup> Daniels (2008) generally follows Scanlon, but he also sometimes uses terms like “liability” and “moral” responsibility too.

As such, if I introduce “new” terms I am likely to create more confusion than clarity. Moreover, from a philosophical point of view, the concepts which the terms casual, moral and consequential responsibility normally latch onto are perfectly adequate for an analysis of the issue of personal responsibility for health. Consequently, I will eschew all other terminology in this thesis even though I will make use of the analysis and arguments provided by the philosophers who have thought it necessary to introduce a new set of terms to properly unpack the concept of responsibility.

#### **1.2.1.1 Causal responsibility**

To attribute causal responsibility to some object or subject is to simply claim that the object or subject in question had some role in bringing about some event or state of affairs (Buetow and Elwyn 2006). To put it formally, X is causally responsible for Y when X has caused Y (Knight & Stemplowska 2011). In a sense, then, this concept is fairly easy to understand and many will think that the concept does not raise any troubling issues from the perspective of *normative* philosophers. However, matters are not so simple because although normative values do not impact on the concept of causal responsibility itself they do impact on the way the concept is used.

How is this possible? When we say that X is causally responsible for Y are we not simply describing the world? The simple answer is “yes”. However, values immediately creep in when we try to determine what “the” cause of an outcome is. In other words, we rely on normative values when we make use of the empirical concept of causal responsibility. For example, none of the “risky” behaviours that I will discuss in this thesis can ever be regarded as the sole cause of any injury or illness.

This is because an unimaginably large number of causal forces are partially responsible for any outcome that occurs in the world (Resnik 2007). If I injure my hand whilst idly playing with a sharp knife my risky behaviour may certainly be described as one of the causes of my injury, but it is not the only cause. The vulnerability of my skin to lacerations by sharp metallic objects is another cause of my injury as is the person who sold me the knife in the first place. A physicist might even insist that the existence of carbon in the universe is also a cause of my injury.

When we talk about the causes of some event in the world we usually concentrate on proximal rather than distal causes and we also tend to ignore “background” causes. For example, a doctor would never explain the cause of a burns injury by referring to the evolution of *Homo sapiens* or the presence of oxygen in the atmosphere. However, the causal explanations that people give is context specific and different experts will, for perfectly reasonable reasons, concentrate on different causal elements when they describe the causes of an event.<sup>5</sup>

When writing a death certificate doctors tend to concentrate on (relatively) proximal causes of death. For example, they might note that death was caused by an infection which was caused by a depleted immune system which was caused by the use of chemotherapy to treat breast cancer. Physiologists, meanwhile, would analyse the cause of death in biochemical terms and would argue that the cause of death was the deprivation of oxygen and other nutrients to core tissues. Public health specialists, meanwhile, would analyse the cause of death in terms of wider social and medical

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<sup>5</sup> As Yoder (2002) argues: “*determining causality for any state of affairs involves a decision – a selection process in which we highlight certain causal factors and relegate others to the background.*”

risk factors for breast cancer such as use of the contraceptive pill, socio economic status and the social pressures which lead women to have children later in life.<sup>6</sup>

The legitimacy of these various different approaches to describing the causes of ill-health makes it very difficult to identify “the” cause of a disease or even to argue that a given causal factor is a substantial cause of disease. This is where normative concepts become relevant because we largely determine which causes to focus on by reference to values and practical considerations. For example, when describing what we take to be the substantive causes of an event we tend to concentrate on causal factors that we can, in theory, control rather than factors that we cannot control. We also focus on factors that are relatively proximal. In the health context we tend to concentrate on such causes as risky behaviours, genes and, to an extent, psycho-social forces – all of which may be described as relatively proximal causes of ill-health.<sup>7</sup>

It would, therefore, be a mistake to think of the way in which we make use of the concept of causal responsibility as devoid of all normative aspects even if the concept itself is strictly descriptive in nature. This may be regarded as somewhat troubling. After all, why should we concentrate on reasonably proximal and non-background causes when describing the substantive cause of an outcome? Are we not sneaking value judgments in by the back door when we do so? In response, all I think that we can say about this issue is that using values to determine which causes we regard as substantive is legitimate as long as we do so openly and as long as we have no reasonable grounds for rejecting such a practice.

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<sup>6</sup> All of these factors are thought to be partially causally responsible for breast cancer.

<sup>7</sup> Wider psycho-social factors are sometimes described as the “*causes of the causes*”, but they are increasingly regarded as proximal causes of ill-health (Krieger 1994; Venkatapuram 2011).

It is conceivable – and certainly logically possible – for human societies to operate in such a way that substantive causes are always associated with very distal and background causes of events instead of the proximal and non-background causes. However, this is not how most societies operate and I do not think that people can reasonably reject that we focus on proximal and non-background causes when trying to identify the substantial causes of outcomes.

As such, I will simply assume for the rest of this thesis that when we discuss “the” cause – or the substantive cause – of ill-health it is perfectly legitimate to specifically focus on the role that genes, behaviour and wider social forces play in causing disease and I will also assume that it is equally legitimate to make normative decisions about moral and consequential responsibility on the basis of the claim that it is the proximal and non-background causes that are the relevant substantive causes of ill-health.<sup>8</sup>

### **1.2.1.2 Moral responsibility**

The concept of moral responsibility raises a whole set of complex issues and two of these generate much heated debate. The first relates to the relationship between the concept of moral responsibility and reactive attitudes like praise and blame and the

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<sup>8</sup> The normative issue inherent in the use of the empirical concept of causation has been much discussed in the legal context. This is because it is necessary to identify “the” cause of an event in order to determine criminal and civil liability (Hart and Honore 1985). Many different theories have been put forward with regard to how “the” cause ought to be determined. However, there is widespread consensus that it is legitimate to concentrate on what have been called “necessary”, “proximal”, “direct”, “effective” or “operative” – as opposed to “remote” or “indirect” causes when determining whether an individual is, legally speaking, causally responsible for an outcome (Honore 2005). Clearly, the decision to concentrate on necessary and proximal causes is value-laden, but the necessity of taking such an approach is widely recognised and accepted by lawyers and lay people alike.

second relates to the conditions that must obtain if people are to be correctly regarded as morally responsible for their actions. I do not have the space to delve into these problems in a great deal of depth here, but I will say a brief word about them in order to clarify what I mean when I say that people are morally responsible for their risky health affecting choices.

Many philosophers argue that an ascription of moral responsibility is intimately related to reactive attitudes. They point out that in everyday life we are generally reluctant to praise or blame someone if we think that they are not morally responsible, but we are quick to do so if we think that they are morally responsible (Glover 1970). However, though there does seem to be a close relationship between the concept of moral responsibility and reactive attitudes like praise and blame, the exact nature of the relationship is rather obscure.

Strawson (1962) argues that being morally responsible for an action or a disposition *just is* being worthy of some kind of reaction for performing the act or cultivating the disposition. The reactive attitudes do not derive from judgments of responsibility. Rather they are constituted by them (Eshleman 2009). Other philosophers demur. Glannon (2002) argues that people who are morally responsible are “open” to reactive attitudes but the existence of moral responsibility needs to be established prior to, and independently of, any reactive attitudes that we may have. Praise or blame, in other words, do not constitute moral responsibility, rather they “track” moral responsibility.

As I see it, Strawson’s approach goes awry in this case and I agree with the general thrust of Glannon’s argument in the sense that I think that the existence of moral



responsibility can be established independently of our reactive attitudes. Indeed, I would actually go further than Glannon in the instance because I think that it is logically possible for an individual to be morally responsible without being “open” to any reactive attitudes at all.

However, whether this latter claim is true or not is unimportant from the perspective of my thesis because what I am concerned with here is not the relationship between moral responsibility and reactive attitudes, but rather the relationship between moral responsibility and cost bearing. It might be thought that cost bearing and reactive attitudes are necessarily linked, but this is not the case because it is possible for people who are morally responsible to bear costs without being the subject of reactive attitudes and *visa versa*. Thus, the question of whether people should be blamed and the question of whether people should bear costs are separate issues. Moreover, because I am only interested in the latter question in this thesis I will ignore the issue of reactive attitudes for the rest of the thesis.

The other issue is much more relevant to my thesis and during the course of chapter 5 I will spend much time discussing the conditions that must obtain if people are to be correctly regarded as morally responsible for their choices. As it happens, the debate about the necessary and sufficient conditions of moral responsibility has been ongoing for over two millennia. In the Western philosophical tradition, for example, the debate originates with Aristotle’s (1984) analysis of voluntary action and his claims that people must be free in some sense – and must possess some amount of knowledge – if they are to be morally responsible.

Most contemporary philosophers agree that three conditions, in particular, are necessary – and possibly sufficient – for moral responsibility. These are the mental capacity condition, the freedom condition and the epistemological condition (Fischer and Ravizza 1998; Glannon 2002; Kelley 2005). However, though there is something of a consensus about the importance of these conditions there remains great disagreement about the nature and meaning of these conditions and even more disagreement about whether these conditions actually obtain in the real world.

In chapter 5 I will explain how I conceive of these conditions and explore whether people are morally responsible for their risky health affecting choices. In particular, I will claim that people are morally responsible when they have a range of conative, cognitive, affective and volitional capacities, when they are free from coercive influences and when they have easy access to relevant and readily comprehensible health information about the risky behaviours that they choose to engage in. I will also argue that in the context of risky choices, all three conditions of moral responsibility usually obtain which means that we have good reason to think that most people are substantively morally responsible for their health affecting choices.

### **1.2.1.3 Consequential responsibility**

Consequential responsibility is, in effect, the responsibility to bear the costs of our choices. Knight and Stemplowska (2011) argue that to say that a person is consequentially responsible for X is to say “*that the burdens and benefits that come with or constitute X are justly his or hers to bear*”. Like the concept of casual

responsibility this concept is easy to understand and there is little debate about the actual meaning of this form of responsibility amongst normative philosophers.

This does not mean that there is a lack of controversy about this concept. In fact, a great deal of disagreement exists about the relationship between this concept of responsibility and the concepts of causal and moral responsibility analysed above. In the context of risky health affecting choices specifically, there is much disagreement about whether people who are morally responsible for their risky health affecting behaviours and causally responsible for their ill-health should bear health costs pursuant to these forms of responsibility.

As I noted earlier, many health care professionals, politicians and policy makers talk, or write, in such a vein that we must assume that they think that moral responsibility is sufficient for consequential responsibility – and some talk, or write, in such a way that they must think that causal responsibility is sufficient for moral responsibility. However, most philosophers believe that consequential responsibility does not simply follow, by necessity, from the existence of either causal or moral responsibility (Glover 1970; Scanlon 1998; Glannon 2002). Veatch (1980), for example, argues that even if patients are morally responsible for taking risks it does not follow that they are “*culpable*” in any sense or that they should necessarily bear costs.

The primary reason why most philosophers baulk at the idea that causal and/or moral responsibility is sufficient for consequential responsibility is because they think that we need further normative justifications for making leaps between the different forms of responsibility. For example, most philosophers would argue that if a pedestrian

runs into a burning building to save the life of a child, the costs of treating the pedestrian's burns injuries should be borne by the state even if the pedestrian was entirely causally responsible for his injuries and entirely morally responsible for taking risks with his health. But, if we agree with this conclusion, we necessarily accept that neither causal nor moral forms of responsibility are sufficient for consequential responsibility. Indeed, if we agree with the conclusion we are committed to finding further normative premises if we wish to argue that people ought to bear the costs of their choices.

As it happens, I think that a number of strong normative arguments can be relied upon to achieve this goal. In particular, the luckist version of the luck egalitarian arguments furnishes us with sufficient reason to justify some forms of cost bearing in situations where people are morally responsible for engaging in the risky health affecting behaviour that caused their ill-health.

However, though there are a number of normative arguments that can help to bridge the gap between causal, moral and consequential responsibility, I accept that not everyone agrees that this is possible and I appreciate that I will have my work cut out in chapter 6 to convince people that this is true.<sup>9</sup> Nevertheless, as I noted earlier, this

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<sup>9</sup> Most of the normative arguments that I will discuss in this thesis will treat moral responsibility as a necessary condition for consequential responsibility. However, there is one exception to the rule: the utilitarian argument. I will explain why this is case in more detail in chapter 6, but the key issue is that utilitarians can defend cost bearing as long as people are causally responsible for their ill-health. This may seem like a strange claim, but the point is that some people will change their behaviour if costs are imposed even though they are not morally responsible for their choices. Young children, for example, will respond to costs (and rewards) even though they are often not morally responsible for the decisions that they make. Thus, in theory at least, people could be held consequentially responsible even when

is one of the primary goals of my thesis and I think that there is good reason to believe that this conclusion can be drawn.

### **1.2.2 Responsibility for acts and responsibility for omissions**

Another key distinction which is often thought to be relevant to notion of responsibility for health is the distinction between acts and omissions. Many philosophers hold that there is a significant difference, from a moral point of view, between what we do and what we fail to do (Stauch 2000). Moreover, those who think that this is the case usually claim that immoral actions are morally worse than immoral omissions. On the other hand, a number of philosophers – especially those of a consequentialist bent – argue that there is no moral difference between acts and omissions (Rachels 1975). They claim that we are as responsible for what we fail to prevent from happening as we are for what we actively bring about.

If we think that the distinction between an act and an omission is morally important then it has direct bearing on the issue of responsibility for health because it implies that there is an important normative difference between risky health affecting which takes the form of acts and risky health affecting behaviour which takes the form of omissions. For example, it would imply that there is a normatively important difference between patients who actively bring about an illness by consuming too much red meat or by drinking too much alcohol and patients who become ill because they failed to take their medication as prescribed or failed to exercise regularly.

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they are not morally responsible for their risky health affecting behaviour from the utilitarian perspective.

Philosophers have spilt much ink discussing the alleged moral difference between an act and an omission and I do not have the space to delve into these arguments here. However, my sympathies lie with those who claim that there is no significant normative difference between acts and omissions and so, for the purposes of my thesis, I will simply assume that the distinction is of no moral importance. In this respect I follow Yoder (2002) who argues that we should “*assign blame not only for behaviours that cause or increase the risk of illness and injury but also for failing to act in ways that might prevent illness or injury*” and so I will assume that people who fall ill because they omit to take care of their health should be judged in exactly the same way as those people who fall ill because they have actively engaged in behaviours that harm them.

### **1.2.3 Moral and legal responsibility**

Few people would deny that a relationship exists between the concepts of moral and legal responsibility and many scholars have argued that the latter concept both reflects and derives its normative significance from the former concept (Corlett 2006).

Nonetheless, moral and legal forms of responsibility do not march in lockstep and an important distinction exists between them. Indeed, in most jurisdictions there are plenty of situations where people can be held legally responsible even though they are not morally responsible – and *visa versa*.<sup>10</sup>

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<sup>10</sup> In cases of strict liability individuals can be held legally responsible for any damage and loss caused by their actions or omissions even when they are not morally responsible in any way (Epstein 1973). Likewise, in many societies people can be deemed morally responsible for an action considered to be immoral (e.g. adultery) without facing any legal sanctions or any claims of legal responsibility in relation to that action.

In this thesis I will occasionally refer to the concept of legal responsibility, but my primary concern will be with the concept of moral responsibility. That said, much can be learnt about the necessary conditions of moral responsibility from an analysis of legal responsibility and my discussion of moral responsibility for health in chapter 5 – and my discussion of consequential responsibility in chapter 6 – will, at least in part, be derived from jurisprudential analysis about the meaning of legal responsibility and the conditions that must obtain if people are to be treated as legally responsible.<sup>11</sup>

#### **1.2.4 Prospective and retrospective responsibility**

Another key distinction that has been mooted in the literature is the distinction between forward looking (prospective) and backward looking (retrospective) notions of responsibility (Kelley 2005). Prospective responsibilities are responsibilities that people have *before* an action or event has taken place (e.g. a smokers' responsibility for the lung cancer he is yet to develop) and retrospective responsibilities are responsibilities that people have *after* an action or event has occurred (e.g. a smokers responsibility for the lung cancer that he has developed as a consequence of his smoking habit). Feiring (2008) notes that policy makers have in the past tended to rely on prospective notions of responsibility for health when devising policies although he also argues that the focus of their work may now be changing.

It is not entirely clear why policy makers have tended to concentrate on prospective responsibility to the exclusion of retrospective responsibility. One possible

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<sup>11</sup> In this respect, I follow Corlett (2006) who argues that the relationship between law and morality is “*symbiotic*” in the sense that legal concepts of responsibility can help us to conceptualise the moral concept of responsibility and visa versa.

explanation for this is the general concern that people may be non-culpably ignorant of the risky nature of the behaviours they engage in and thus they should not be regarded as morally or consequentially responsible for their choices until they have had the opportunity to learn about these risks. In other words, we must wait until people have developed a disease and had contact with health care professionals before arguing that they have had access to sufficient information to be morally responsible for their choices.

It is worth noticing that this objection does not turn on the basis that retrospective responsibility is backward looking, but on the empirical claim that people do not have sufficient access to sufficient health information to justify policies based on retrospective responsibility. This is important because, as I will argue in chapter 5, there is little evidence to suggest that this empirical claim is true and so there are good reasons to think that those who have previously opposed retrospective responsibility on the basis of this claim ought to change their minds.

Since I think that most people do have access to sufficient information to be morally responsible before they take risks it would be unfair for policy makers to concentrate their fire on prospective forms of health responsibility. If we are going to hold people to account failing to be morally responsible in the future we should also hold people to account if they were equally morally responsible in the past – otherwise we will be guilty of treating people who are in normatively similar positions in different ways for arbitrary reasons. For these reasons, I will make use of both retrospective and prospective concepts in my thesis and I will assume that there is no relevant normative difference between them.



### 1.2.5 Personal and collective responsibility

Another distinction which is often referred to in debates about responsibility for health is the distinction between personal and collective responsibility. Collective responsibility refers to the responsibility of organisations or groups whilst personal responsibility refers to the responsibility of individuals (Agich 1982).<sup>12</sup>

In this thesis I will concentrate overwhelmingly on the issue of personal responsibility for health. In so doing, I do not mean to imply that collective responsibility is irrelevant to issue of responsibility for health. Governments, corporations, civil society and families have responsibilities in relation to health which are both vast and complex. For example, governments have a responsibility to regulate the production, sale and marketing of certain substances (e.g. tobacco) and they have a responsibility to ensure that people actually have opportunities to engage in healthy behaviour.

In this respect, I agree with Forde and Raine (2005) who argue that “*responsibility for better health should be shared between society and the individual*”. I also accept that if we concentrate on personal responsibility to the exclusion of collective responsibility there is a danger that we will be distracted from other sources of ill-health, such as environmental health hazards, which have nothing to do with risky behaviours (Wikler 1976).

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<sup>12</sup> Individual agents may have responsibilities as members of various groups as well as responsibilities *qua* individuals, but when I talk of personal responsibility I simply mean those responsibilities that individuals have *qua* individuals.

For these reasons, I will not entirely ignore the issue of collective responsibility in this thesis and in chapter 5 I will discuss the responsibility of the state to ensure that people have enough information about the associations between behaviour and ill-health to make informed decisions. However, although the issue of collective responsibility for health is extremely important I have opted to concentrate my energies on the concept of personal responsibility for health. I have explained earlier why there is a pressing need to do this, but I want to reiterate here that nothing I say in this thesis about the issue of personal responsibility is intended to suggest that other entities (such as corporations and governments) have no responsibilities in relation to health or that the concept of collective responsibility is normatively unimportant.

#### **1.2.6 Role and non-role responsibility**

When discussing responsibility for health many scholars distinguish between what has been called role and non-role responsibility (Hart 1968; Buetow and Elwyn 2006). Different social and legal roles carry with them specific responsibilities. Most notably, people in office have specific responsibilities to fulfil the duties attached to those offices. Hence politicians, judges and health care professionals all have specific duties and responsibilities as a consequence of their positions. Beyond these responsibilities of office, people in various social roles also have specific responsibilities in virtue of being in these social roles. Thus parents, siblings and friends might have responsibilities to other people which have nothing to do with their jobs or the requirements of the law.

Non-role responsibilities are responsibilities incumbent on us independently of any given role that we might have. For example, we all have a responsibility not to harm other people without good reason just in virtue of the fact that they are people. This has nothing to do with any social role that any of us have. Likewise, it could be argued that people have a responsibility to look after their health because failing to do so might reduce the amount of resources available to others. Again, such responsibilities have nothing to do with any social or official role that we might have.

For the purposes of this thesis I will stick to the concept of non-role responsibility for health. This is not to deny that role responsibilities are important, but the concept is neither necessary nor helpful in terms of explicating people's personal responsibilities for their health. Perhaps there is some scope for the notion of role responsibility where we speak of people who have adopted the "role" of a patient. The Scottish NHS Patients' Charter talks in this vein when it mentions the rights and responsibilities of patients (Department of Health Scotland 2006). However, to claim that a patient has adopted a kind of social "role" is a somewhat dubious one and even if we were to adopt such an approach, it would not help us to delineate or explain the health responsibilities of people who are not yet patients.

### **1.2.7 Complete and partial responsibility**

The last distinction that I wish to draw attention to is the distinction between complete and partial responsibility for health. There is a natural tendency to think of causal, moral and consequential responsibility in absolute terms. In particular, there is a tendency for some health care professionals to describe their patients as either being morally responsible or not being morally responsible for their risky behaviour.

However, matters are usually much more complicated than this and we must resist the temptation of thinking in “all or nothing” terms.

The need for a gradualist approach in relation to causal, moral and consequential responsibility will become more apparent when I discuss these concepts in chapters 4, 5, 6 and 7. In chapter 4 I will note that the aetiology of most diseases is multi-factorial and in chapter 5 I will argue that people’s degree of moral responsibility is often a matter of degree. I will also argue in chapters 6 and 7 that an awareness of the partiality of causal and moral responsibility is crucial from the point of view of consequential responsibility because it would be unjust (from most points of view) to put in place cost bearing policies which required people to bear full costs when their degree of causal and moral responsibility is limited.<sup>13</sup>

However, although I accept that health care policies must be alive to the fact that causal and moral responsibility for health is usually a matter of degree, I also concede that it is difficult to devise public policies that ensure that the cost that patients actually bear maps directly onto the costs that they should bear. This is primarily because it is so hard to determine exactly how causally and morally responsible people are.

Nonetheless, because it is very important to ensure that people are not made to bear more costs than they ought to bear I will only discuss cost bearing policies in this thesis that can accommodate the fact that causal and moral responsibility is usually a

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<sup>13</sup> A gradualist approach to legal responsibility is also adopted in many jurisdictions. For example, in the UK and the USA the concept of “diminished” responsibility is widely accepted (Glover 1970).

matter of degree. This will make the cost bearing policies that I analyse more complex than they would otherwise need to be, but this is a bullet that we simply have to bite.

### **1.3 The structure of the thesis**

This thesis will effectively proceed through six main “phases”. The first phase will involve a brief historical analysis of the concept of personal responsibility for health through the ages – with a particular focus on the way in which the concept has been used by politicians and policy makers since the 1970s. The second phase will involve a discussion of the popularity of the idea that people who take risks with their health should bear some kind of health cost amongst the lay public, health care professionals and patients.

The third phase will involve an analysis of the claim that people are causally responsible for a significant portion of the global burden of disease. The fourth phase will explore some of the necessary conditions of moral responsibility and will aim to demonstrate that a significant number of people are substantively morally responsible for their risky health affecting behaviour. The fifth phase will address the issue of consequential responsibility and will aim to explain why people who are causally and morally responsible should also be consequentially responsible for their ill-health. The sixth phase will involve a review of the various ways in which the concept of consequential responsibility can be cashed out in terms of health care policies which place cost bearing at their heart.

To conclude this introductory chapter I will flesh out these phases in a little more detail by briefly outlining the content of each of the eight chapters that will constitute this thesis.

### **1.3.1 Chapter 1**

In this chapter I have explained why it is important to address the issue of responsibility-sensitive cost bearing as a matter of some urgency and I have provided a brief analysis of the concept of responsibility. I have also summarised the main “phases” of my thesis and I am now going to end this chapter by outlining the content of each of the remaining chapters.

### **1.3.2 Chapter 2**

In the second chapter I will provide a brief synopsis of the history of the concept of personal responsibility for health. I will begin by noting that for most of human history an accurate understanding of the association between human behaviour and ill-health was probably confined to the relationship between overtly risky behaviours and the physical injuries that they could cause. I will then discuss how Hippocrates, Galen and other Ancient physicians understood the concept of personal responsibility for health before providing a brief account of the development of this concept through to the middle of the 20<sup>th</sup> century. At this point my discussion will become much more detailed and I will provide an in-depth analysis of the way in which the concept of personal responsibility for health was developed and deployed by policy makers and politicians from the 1970s to the early 21<sup>st</sup> century.

I will not attempt to provide an exhaustive historical analysis of the use (and abuse) of the concept of personal responsibility in this thesis. As a non-historian such a task is beyond my ken and, in any case, the way in which the concept developed through human history does not affect the arguments that I will later mount in defence of cost bearing in relation to risky health affecting behaviours.

Nonetheless, it is important to begin this thesis with a general overview of the history of the concept of personal responsibility for health for three main reasons. Firstly, it is salutary for anyone interested in a concept to learn how it was understood in the past because this will help them think about the way in which the history of a concept influences our current use of the concept. Secondly, it is important for philosophers who analyse the issue of responsibility for health to understand that, although the concept of personal responsibility for health has been with us for many millennia, it is only now beginning to dominate discussions of health care policy. This is important because it serves to reinforce the need to address the issue of cost bearing as a matter of urgency. Thirdly, if we are interested in devising health care policies it is important to have an understanding of the historical context in which the concept of personal responsibility developed because public policies which operate in a historical vacuum are more likely to be rejected by citizens who are, consciously or otherwise, affected by the impact that this conceptual development has had on their social values.

### **1.3.3 Chapter 3**

In the third chapter I will present and analyse the views of the lay-public, health care professionals and patients about cost-bearing in relation to risky health affecting

behaviours. My primary reason for discussing the views of the lay-public is to demonstrate that there is a groundswell of support for responsibility-sensitive cost bearing policies both in the UK and in other developed countries. Needless to say, the popularity of a concept should not automatically determine that it should form the basis of public policies. However, in democratic societies, policy makers and politicians must take some account of the views of the lay public and must try to accommodate their beliefs and values to a considerable extent. Legislators must also pay special heed to those people who will be most directly affected by health policies (i.e. patients) and those who best understand the provision of healthcare (i.e. health care professionals).

As we shall see, the initial surveys, which were conducted in the last decades of the 20<sup>th</sup> century, were fairly basic in their approach, but they gave clear hints that many lay people believed that patients should sometimes bear at least some of the costs of their risky health affecting choices. More recent studies have tried to unpack these beliefs in more detail and although very detailed surveys are still lacking we now have a much better understanding of the democratic credentials of responsibility for health policies in general and cost bearing policies in particular. Far less is known about the views of health care professionals and patients, but a small number of surveys have attempted to glean information about what these important groups think about these issues and I will review and discuss this data in chapter 3 too.



### 1.3.4 Chapter 4

In the fourth chapter I will discuss the issue of causal responsibility for health and ill-health. I will begin by providing an overview of how significant a role human behaviour is thought to play in contributing to the global burden of disease and I will then discuss a whole range of different behaviours and the evidence that exists to suggest that these behaviours cause disease. In the process, I will not only discuss the most well-known associations between behaviours and disease (e.g. the association between smoking and lung cancer), but also the less appreciated links (e.g. the association between Human Papilloma Virus and cervical cancer). I will also make a point of discussing the fact that many “everyday” behaviours (such as driving a car) and many socially acceptable behaviours (such as having unprotected sex with the intention of getting pregnant) are themselves risky and often cause injuries and illnesses.

I will not provide a comprehensive list of all the known causal links between human behaviour and ill-health in chapter 4. Nor will I present all the evidence that has been marshalled to defend the causal associations that I will discuss. This is because doing so would take up far too much space and providing this much data will not affect the central argument of this thesis. Nevertheless, I will devote an entire chapter to this topic because I want to underline just how substantial a role human behaviour plays in determining people’s health and ill-health. This is important because it is easy for non-health care professionals to fail to appreciate just how much of our own health is, causally speaking, in our own hands.

### **1.3.5. Chapter 5**

In the fifth chapter I will move on to discuss more philosophical matters. I will elucidate the concept of moral responsibility in more detail and I will also discuss three of the necessary conditions that must obtain if people are to be morally responsible for their risky health affecting behaviour. The chapter will be divided into three main sections. The first section will deal with the mental capacity condition, the second section will deal with the freedom condition and the third section will deal with the epistemological condition.

In the first section, I will argue that people need a range of conative, cognitive, affective and volitional capacities to be morally responsible for their risky health affecting choices. These will include the capacity to respond to reasons and act on the basis of reasons rather than desires. In the second section, I will argue that people must be free in order to be morally responsible for their risky behaviour and I will explore what this condition really amounts to. My key conclusion in this section will be that freedom should be understood in a compatibilist sense and that the best understanding of compatibilist freedom is the “no coercion” conception of freedom. In the third section, I will argue that people need access to relevant, easily accessible and readily comprehensible information about risky health affecting behaviours if they are to be morally responsible for choosing to engage in these behaviours. I will also argue that people can avoid the charge of moral responsibility, even if information is available, if their ignorance is non-culpable.

In the process of discussing these conditions of moral responsibility I will argue that most people are substantially morally responsible for their risky health affecting choices. This is because, in most cases, the mental capacity, freedom and epistemological conditions do obtain in the real world. In other words, most people have sufficient mental capacity to be morally responsible for their risky behaviour from the perspective of the mental capacity condition and they are also sufficiently free and have access to sufficient information to be morally responsible from the perspective of the freedom and epistemological conditions. Exceptions to the rule do exist and I will argue in this chapter that certain groups of people (e.g. young children and people suffering from serious brain injury) lack any moral responsibility for their risky behaviour, whilst other groups (e.g. those affected by various genetic disorders) are less morally responsible than other people. However, my general conclusion in this chapter will be that, in most cases, moral responsibility for risky health affecting behaviour exists to a relatively high degree.

### **1.3.6 Chapter 6**

The sixth chapter will focus on the normative question of whether people who are causally and/or morally responsible should also be regarded as consequentially responsible for their ill-health. During the course of the chapter I will present, discuss and analyse five different normative arguments which provide grounds for thinking that some people should bear some of the costs of their risky choices. These arguments, as I noted above, will be dubbed the “moralistic desert”, “expected consequences”, “rights-harm”, “luck egalitarian” and “utilitarian” arguments.

My primary conclusion in this chapter will be that these five arguments converge together to defend the idea that people should bear costs when they engage in what I shall call “core” risky health affecting behaviours. I will also argue that the luck egalitarian argument is the most robust of the five arguments and that there are serious, though perhaps not fatal, problems with the other four arguments. In particular, I will argue that the moralistic desert argument has trouble dealing with the objection that self harming behaviour is not really intrinsically immoral and that, even if it is, there are many reasons to think that the state should not intervene to penalise such behaviour. I will also argue that the expected consequences argument is very vulnerable to the claim that it cannot independently ground claims of cost bearing and that the rights-harm argument has implications which few rights-theorists are likely to find palatable. Finally, I will argue that the utilitarian argument rests on empirical claims which are difficult to prove.

This is not to say that adequate rejoinders to these objections cannot be formulated. Nor do I suggest that the luck egalitarian argument is devoid of problems. However, defenders of the moralistic desert, expected consequences, rights-harm and utilitarian arguments have much work to do to defend their various approaches to the issue of cost bearing and, as I see it, the luck egalitarian argument is the most normatively compelling argument by far.

### **1.3.7 Chapter 7**

In seventh chapter I will discuss five policy options that would, if they were implemented, ensure that people would bear some of the costs of their choices. As I

noted earlier, the five policy options that I will analyse are the “denial of access to health care”, “payment”, “reduced priority”, “risk tax” and “risk insurance” policies. In the process of outlining and discussing these policies I will seek to explain their strengths and weaknesses and I will offer my own views as to which of these policies is most normatively legitimate and practically feasible. In particular, I will claim that the risk tax and the risk insurance policies are the most defensible of all the cost bearing policies and they are the only policies which can be defended by all five of the normative arguments that I will discuss in chapter 7. Moreover, I will argue that there is a particularly good “fit” between the strongest of the normative arguments that I will discuss in chapter 7 (i.e. the luck egalitarian argument) and the risk tax and risk insurance policies.

My general conclusion in this chapter will be that if governments wish to implement cost bearing policies they should do so by requiring people to pay risk taxes and/or risk insurance premiums. I will also strongly suggest that other forms of cost bearing policies – many of which have already been utilised by governments around the developed world – should be avoided.

### **1.3.8 Chapter 8**

In the eighth and final chapter I will sum up my arguments, suggest avenues for further research and bring my thesis to a close. In terms of future research I will, amongst other things, argue that further work is urgently needed to find out more about the views of the public, health care professionals and patients regarding the concept of personal responsibility for health in general and the concept of

consequential responsibility in particular. This is because we still have very little understanding of what these groups really think about cost bearing policies and even less understanding of why so many people think that cost bearing is legitimate.

I will also argue that further research is needed to determine the impact that recent developments in genetic screening and treatment will have on the issue of responsibility for health. This is because there is good *prima facie* reason to think that these developments will radically increase the number of people who can be responsible for their health. Finally, I will argue that more work needs to be done to explore the relevance of the arguments that I have discussed in this thesis to the world of bio-medical research. This is important because it is possible that we could modify the way this kind of research is carried out in order to make people bear the costs of their choices in an entirely novel way.

## Chapter 2

### Responsibility for Health: A Brief History of an Idea

*“Walking is man's best medicine.”*

– Hippocrates

#### 2.0 Introduction

The debate about the importance of personal responsibility for health has waxed and waned throughout human history. In this chapter I will provide a brief overview of the history of this concept with a special emphasis on the way in which the concept has been deployed in the public health arena between the middle of the 20<sup>th</sup> century and the beginning of the 21<sup>st</sup> century. My primary goal is to contextualise the modern debate about personal responsibility but I am also keen to explain why the concept of consequential responsibility is only now beginning to find itself at the heart of policy discussions. Providing this historical synopsis will also enable me to demonstrate how many of the cost-bearing policies that I will analyse in the penultimate chapter of this thesis have already been implemented across the developed world.

#### 2.1 From early man to the mid 20<sup>th</sup> century

We know very little about the values and beliefs of early *Homo sapiens* and we know even less about their understanding of health, illness and the concept of personal responsibility for health. It is likely that human beings have always had a sound grasp of the causal association between trauma and injury for it does not take much imagination to understand that the human body can be easily damaged by physical

objects in the world. It is also possible that early man understood that less overtly dangerous behaviours could cause disease.

Contemporary anthropologists, for example, point out that in many “primitive” societies so called “medicine men” have a surprisingly good grasp of the causes of some diseases and an even better understanding of the natural remedies that can be used to treat these diseases (Halifax 1988). Moreover, a number of anthropologists have also observed that people living in these societies often perceive ill-health to be a form of divine punishment (Galvin 2002).

Nonetheless, although these anthropological findings give us tantalising clues about how our ancestors might have understood the concepts of causal, moral and consequential responsibility we can only really speculate about the health beliefs of early man. We must wait until recorded history begins in order to make well founded claims about how people understood these concepts.

In the Western world the first extant evidence that we possess about how earlier generations understood the concept of personal responsibility for health is to be found in the writings of Ancient Greek and Roman physicians (Veatch 1980; Leichter 1981). From what little remains of their written work we can infer that very many Ancient physicians were extremely interested in the idea that human beings were causally responsible for some aspects of their own health and ill-health and this awareness of the causal role of human behaviour in the aetiology of disease seems to



have encouraged a number of Ancient physicians to develop the medical discipline that we now call “preventative medicine” (Minkler 1999).<sup>14</sup>

Many of the Ancient beliefs about the causes of disease were erroneous and some of their prescriptions for a healthy life were downright dangerous (Porter 2003).

Nonetheless, many Ancient physicians, including Hippocrates and Galen, were committed to the idea that a judicious mixture of physical exercise and the consumption of a balanced diet would lead to a healthier and longer life – claims which have now been validated by modern epidemiologists (Reiser 1985).

A number of these Ancient physicians also “moralised” the issue of personal responsibility for health in a way that has become familiar to us at the beginning of the 21<sup>st</sup> century. For example, in his text on *Hygeine*, Galen (1951) asks:

*“Is it not shameful that a man with a perfect constitution should have to be carried by others on account of gout, or should be tortured with the pains of calculus, or suffer pain in the colon or have an ulcer in the bladder from indigestion?”*

Galen here is giving voice to the oft repeated claim that there is something morally amiss about someone who could have been healthy but has developed some kind of illness or injury as a result of their own risky behaviour. Unfortunately, it is unclear from this passage *why* Galen thought it was “shameful” for a man to suffer from an illness he could have avoided. Perhaps he believed that patients had a duty to

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<sup>14</sup> Reiser (1985) also argues that Ancient physicians also understood that social class influenced people’s ability to control their own health.

themselves to take steps to remain healthy. Alternatively, he might have thought that people had a duty to the state to achieve and maintain good health. Reiser (1985) argues that such beliefs were prevalent in the Ancient world and it may be that in this extract Galen is giving voice to these values.

Even if we accept the popularity of these views, it is far from clear whether many Ancient physicians and citizens would also have believed that those who were “guilty” of such moral infractions should also be regarded as consequentially responsible for their ill-health. It is possible to detect a hint of such beliefs in some of the Ancient physician’s writings on these matters, but the sources that remain simply do not provide us with enough evidence to prove this one way or another.

Consequently, it is difficult for us to know how many people in the Greco-Roman world believed that some people who took risks with their health should bear the costs of their choices.

Whatever the truth of the matter, we can be sure that the concepts of causal, moral and consequential responsibility survived the fall of the Ancient world. Gouret, writing in the 16<sup>th</sup> century argued that diseases were caused by, amongst other things, an excess of “*meat and drink*” and the “*immoderate use of lechery*” and he argues that such views were very common in what we now call the “Dark” and “Middle” Ages (Slack 1979). However, it seems that the Ancient emphasis on preventative health was somewhat diluted during these eras. Moreover, Reiser (1985) contends that there was a greater willingness amongst medieval apothecaries, physicians and theologians to attribute diseases to lack of moral virtue than was the case in the Ancient world.

It has also been argued that, throughout the Dark and Middle Ages, many people saw God's wrathful hand in the aetiology of health and disease and there is good evidence that many people believed that ill-health death was a punishment for some kind of trespass against God whilst good health was a reward for a life of virtue (Slack 1979). Moreover, people came to regard their bodies as the "houses" of their souls during this time which meant that many people believed that looking after their health was a duty owed to God – rather than a prudential or moral duty to oneself or other people (Reiser 1985).

However, although it is tempting to believe that the whole concept of personal responsibility for health became highly moralised in the Dark and Middle Ages we should recall that Galen and many other Ancient physicians conceived of personal responsibility for health in moralised terms too. Furthermore, there is plenty of evidence to suggest that many apothecaries and physicians in the Dark and Middle ages were entirely aware of some of the casual associations between behaviours and disease.

As such, we should be somewhat wary of the claim that the Ancients had a sound, non-moralised, grasp of the aetiology of many diseases whilst physicians in the medieval world were more interested in a moralised conception of ill-health. There may be some truth to this claim, but we lack the evidence to be sure that this was the case.

What we can be sure about is that, during the Renaissance and the early modern period, the concept of personal responsibility for health continued to influence

people's beliefs and that more systematic attempts were made to decipher the aetiology of disease from a physical, rather than a spiritual, perspective (Porter 2003). For example, during the Renaissance Corato published a popular treatise which advocated a lifestyle of moderation and he also set about trying to explain the “*humanistic*” rather than the divine origin of disease and many other Renaissance scholars – including the polymath Leonardo da Vinci – also began to conduct basic medical experiments at this time to try and uncover the physical causes of some common diseases (Sigerist 1956; Nicholl 2005).<sup>15</sup>

Nonetheless, it was not until the advent of modern biology, medicine and epidemiology in the 18<sup>th</sup> and 19<sup>th</sup> centuries that a scientific and statistical study of the physical causes of disease was begun in earnest. Consequently, it was not until the advent of the modern era that humanities' understanding of the causal role of human behaviour in the aetiology of disease was finally placed on a solid foundation (Minkler 1999). The first real breakthrough did not occur until the 19<sup>th</sup> century when the microbiological work of Pasteur and Koch, the clinical work of Semmelweis and Lister and the epidemiological work of Snow and his colleagues unearthed the existence of microbes and the way in which human behaviour could either retard or encourage the spread of infectious disease (Porter 2003).

These discoveries and others like them seem to have fired the popular imagination of Europeans and helped to launch a new “personal responsibility” drive in many developed countries at this time. The Victorians, in particular, were very influenced by these discoveries and many Victorian scholars openly defended the idea that good

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<sup>15</sup> Amongst many other suggestions Corato argued that people should only drink and eat enough “*to keep the body and soul together*” (Sigerist 1956).

hygiene and other behavioural traits could diminish the probability of developing diseases (Minkler 1999). Moreover, Reiser (1985) argues that European and American literature during this time was replete with information about how to remain healthy and with advertisements for institutions “*designed to keep the body fit, such as spas and gymnasiums*”.

Many Victorians were also quick to draw moral conclusions from the growing empirical evidence that human behaviour was causally implicated in the aetiology of many diseases. A number of Victorian physicians argued that living a long and healthy life was some kind of moral “*reward*” for a life of self control and careful prudence (Minkler 1999). Butler even wrote a novel, *Erewhon*, in 1872 about a world in which people who were ill were not only regarded as morally culpable but were also punished (Galvin 2002). The relative popularity of this book indicates that the concept of consequential responsibility was very much in vogue during this time and there is much evidence to suggest that physicians and lay people alike advocated cost bearing policies during this era (Reiser 1985).

## **2.2 From the middle of the 20<sup>th</sup> century to the beginning of the 21<sup>st</sup> century**

For all the discoveries made during the scientific revolution in biology during the 18<sup>th</sup> and 19<sup>th</sup> century, a thoroughgoing understanding of the aetiology of disease had to wait until the late 20<sup>th</sup> century and it was not until near the beginning of the 21<sup>st</sup> century that the causal importance of personal behaviour in the aetiology of disease

was grasped in its full magnitude.<sup>16</sup> Interestingly, the growing empirical evidence about the importance of human behaviour did not immediately affect health policy. More than twenty years elapsed between the discovery that smoking was a major cause of lung cancer and the publication of the first policy document which made direct reference to the concept of personal responsibility for health.

However, as the evidence began to accumulate the importance of the concept of personal responsibility did begin to percolate from the medical to the political world and, in 1974, one of the seminal moments in the history of the concept of personal responsibility for health occurred when the Lalonde Report was published in Canada (Lalonde 1974). The Lalonde Report was decisive because it was the first major health policy document to directly refer to the causal role of human behaviour in the aetiology of disease and it was also the first policy report to place any real emphasis on the importance of personal responsibility for health from the perspective of improving human health in the future (Galvin 2002).

The Lalonde report was not centred on the issue of personal responsibility for health. It was rather a broad policy document which covered many aspects of health policy and it explicitly stated that “*lifestyle*” was only one of four major factors that influenced health (Leichter 1981).<sup>17</sup> However, because this report was the first to place any real weight on the role of human behaviour in the aetiology of disease it

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<sup>16</sup> Veatch (1980) argues that even in the middle of the 20<sup>th</sup> century, ill-health was largely attributed to “*mysterious, uncontrollable micro-organisms or the random process of genetic fate*” and he also suggests that the concept of personal responsibility for health did not take centre stage until the latter stages of the 20<sup>th</sup> century when evidence began to accumulate which suggested that many non-communicable diseases were linked to human behaviour.

<sup>17</sup> The other factors were human biology, health care organisation and the environment.

assumed a significance that it probably would not otherwise have had.<sup>18</sup> In fact, once the Lalonde report was published, the floodgates opened and within a decade many governments around the developed world had published health policy reports which made specific reference to the role of human behaviour in causing ill-health and tried to suggest ways of tackling this problem.

Of these, perhaps the most important and influential was the American report entitled “Healthy People” (United States Public Health Service 1979). As with the Lalonde report the Healthy People report had a broad scope, but it unequivocally stated that risky behaviour played a key causal role in the aetiology of many diseases and it also made a number of startling claims that seemed to act as a serious wake up call in the medical and health policy communities. Among these was the factual claim that “*half of US mortality in 1976 was due to unhealthy behaviour or lifestyle*” and the rather emotive claim that the people of the US were “*killing [themselves]...by [their] own careless habits*”.

The British response to the Lalonde report was delineated in a policy document called “Prevention and Health: Everybody’s Business” (Leichter 1981). This document stated that society and government had a responsibility to improve people’s health, but it also made clear that “*the weight of responsibility for [people’s] health lies on the shoulders of the individual himself. Smoking related diseases, alcoholism and other drug dependencies, obesity and its consequences, and the sexually transmitted disease are among the preventable diseases of our time and in relation to all these the*

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<sup>18</sup> Galvin (2002) argues that the report was responsible for the birth of the term “*health promotion*” and that much subsequent health policy and legislation relating to responsibility for health derives from this report.

*individual must choose for himself*” (Department of Health 1976). The Conservative government at the time formally responded to the report in a White Paper which was called “Prevention and Health” which affirmed that the greatest scope for improving health now lay with “*seeking to modify attitudes and behaviour in relation to health*” (Department of Health 1977).

Importantly, none of reports and policy documents published in the 1970s and 1980s moralised the issue of personal responsibility for health (Wikler 2002). Thus, although the reports made many empirical claims about the associations between human behaviour and ill-health, they did not discuss the issue of moral responsibility for health, nor did they mention the idea that people who take risks with their health should bear the costs of their choices.<sup>19</sup> Instead, the reports tended to emphasise the positive aspects of the new knowledge about the link between human behaviour and ill-health. For example, the “Healthy People” report argued that this new understanding meant that human beings now had more control over their own health than they had previously imagined and it noted that this knowledge would help to increase people’s health and welfare in the future.

These reports also placed great emphasis on the environmental and social causes of disease and made it clear that harmful social conditions played a key role in causing disease. Nonetheless, they did help to trigger a debate about the issue of moral responsibility for health and many argue that they paved the way for the incorporation of the concept of consequential responsibility in public health policies because they

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<sup>19</sup> None of the 23 recommendations set out in the Lalonde report recommended any form of sanction or cost bearing in relation to risky health affecting behaviour (Leichter 1981).



placed more weight on personal, rather than collective, responsibility for health (Minkler 1999).

Physicians were also quick to seize upon the epidemiological and biological data that began to emerge in the middle of the last century which demonstrated that there was a causal link between a variety of behaviours and a number of common diseases. Some of these physicians were much less reticent to moralise the issue and to demand cost bearing as a response to risky behaviour than their policy making peers.

One of the first doctors to sink his teeth into this issue was Knowles (1977) who forcefully argued in a much quoted article that “*the idea of a right to healthcare should be replaced by the idea of an individual moral obligation to preserve one’s own health – a public duty if you will*”.<sup>20</sup> Knowles went on to argue that “*one man’s freedom in health is another man’s shackles in taxes and insurance premiums*” and he made it very clear in his article that he viewed irresponsible behaviour as a “*vicious*” and that people who engaged in such behaviour should bear the costs of doing so. More specifically, he decried the “*cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy and smoking*” and suggested that people should be consequentially responsible for engaging in these activities.

Knowles’ infamous article was as seminal for the medical community as the Lalonde report was for the health policy community. This was partly because it was one of the first papers published in a major medical journal to specifically address the question

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<sup>20</sup> Kass (1975) had earlier argued that “*health is a duty...one has an obligation to preserve one’s own health*” and Charrette (1976) has also claimed that “*if people choose to commit suicide in slow and costly ways, perhaps they should share the financial burden that they impose upon society*”.

of personal responsibility for health, but it was also because it addressed the issue in a particularly frank and robust fashion. The article quickly became notorious and inspired a torrent of responses. Some commentators lambasted Knowles for his ideas – Crawford (1977) argued that Knowles was adopting the ideology of “*victim blaming*” and was trying to reinvent the idea that “*sickness was a sin*” – whilst others were more sympathetic.

A number of philosophers, most notably Wikler (1978, 1985, 1987) and Veatch (1980), also responded to the article and their work may be fairly described as the first philosophical attempt to analyse the concept of personal responsibility as it applies to health.

After a short lull in the mid to late 1980s, the debate about the role of personal responsibility for health in the medical and bioethical world was rekindled in 1991 with the publication of two papers in the same volume of the Journal of the American Medical Association. In their paper, Moss and Siegler (1991) defended the claim that patients suffering from liver disease caused by alcohol should receive lower priority for liver transplants than patients who suffered from other causes of liver disease. Cohen and Benjamin (1991) opposed these arguments and warned of the moral danger of making allocation decisions on the basis of responsibility for health.

Two years later the debate was reignited on the other side of the Atlantic when two doctors, Underwood and Bailey (1993) published a paper in the British Medical Journal arguing that coronary bypass surgery should not be offered to smokers. This

paper was published alongside a dissenting paper by Shiu (1993) who argued that such a refusal of treatment was unethical and set a “*dangerous precedent*”.

These four articles sparked ferocious debate about the role of responsibility in the allocation of scarce health care resources and both journals were inundated with letters and comments – many of which were published in other editions of the journals (Sharkey & Gillam 2010). Whilst physicians and a small number of bioethicists were still debating these issues, however, politicians, policy makers and legislators took action.

The legislative response began in Germany where, in 1988, the German parliament amended the German Social Security Code (Sozialgesetzbuch) and became the first government in the world to devise legislation which made direct reference to the concept of personal responsibility for health. Article 1 of the new “Book V” of the German Social Security Code made it clear that German nationals had “*co-responsibility*” for their health and that they had a duty to “*lead a health-conscious lifestyle, take part in appropriately timed preventative measures [and] play an active role in treatment and rehabilitation, [in order to] avoid sickness and disability, and overcome the respective consequences.*” (Schmidt 2007b).

Article 1 also stated that co-payments could be demanded when treatment was required as a consequence of criminal activity, deliberate self-harm, or where

treatment was needed because of problems associated with piercing, cosmetic surgery or tattoos (Schmidt 2008).<sup>21</sup>

The new law also allowed German statutory health insurance schemes to offer incentives to people to try and improve their health. Article 65a of the Social Security Code allowed insurance organisations to offer a “*bonus*” for patients who agreed to attend screening or routine check-ups. These bonuses could take the form of reductions in insurance premiums, cash payments or “*payments in kind*” (e.g. in the form of free sports equipment). Article 62 stated that patients who were willing to attend counselling services for breast, cervical and bowel cancer could ask for their treatment co-payment fees to be reduced if they developed any of these diseases (Schmidt 2009c).

Once the legislation came into force at the end of the 1980s, German health insurance schemes (or “sickness funds”) invented a whole array of novel incentive schemes. One of the biggest sickness funds, Barmer Ersatzkasse, used the new legislation to offer incentives to those who purchased health insurance. This included a bonus points scheme for a range of different health activities (Schmidt 2009c). A selection of the health activities that warrant bonus points in the Barmer Ersatzkasse scheme can be found in Figure 1.0 below.

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<sup>21</sup> Not long after the legislation came into force some patients were denied free treatment for complications that arose as a result of bungled cosmetic surgery or body piercing and so Germany became the first country to require some of its citizens to become consequentially responsible for some of their risky health affecting behaviour (Schmidt 2007b).

**Figure 1.0 Barmer Ersatzkasse Bonus Programme – adapted from Schmidt (2009c).**

<b>Intervention</b>	<b>Bonus Reward Points</b>
Annual screening for chronic disease and measures for primary prevention from age 35	200 per check-up
Prenatal Care	200 per pregnancy
Smoking Cessation	150
Nutrition Classes	150
Male and Female Cancer Screening	200
Recommended Vaccinations	100 a year
Licensed Exercise Classes	100-150 per programme
Active membership in a licensed sports club or fitness studio	150 a year
Relaxation Classes	100-150

The way that the Barmer Ersatzkasse system works is as follows. Every “client” of the company receives a “bonus card” and credits are added to this card when they engage in certain types of health-benefiting activities. The reward points are converted to “real” rewards if clients reach a certain points threshold within a specified period of time. The rewards can either be a cash payment or a payment in kind. For example, 500 points may be exchanged for cash or it may be exchanged for sports watches, cycle helmets and even short “wellness” holidays.

Germany, then, can stake a fair claim to having been the first country to implement cost bearing (and non-cost bearing) policies based on the concept of responsibility for health. However, a number of other countries quickly followed suit. For example, in the 1990s a number of states in the USA devised and implemented health care policies which were designed to encourage personal responsibility for health, and not long afterwards, similar policies were put in place in countries as culturally different as Japan and Denmark (Schmidt 2007a).

In the USA, West Virginia took the lead when the West Virginia Health Plan was enacted just before the turn of the century (Steinbrook 2006). The West Virginia Health Plan was designed to provide incentives for people to become healthier. Recipients of publicly funded health care were given a “*basic*” health insurance plan unless they agreed to abide by certain provisions of a “*membership agreement*” which enabled them to have access to an “*enhanced*” health insurance plan (Schmidt 2007a). Patients who signed up to the enhanced plan would be demoted to the basic plan if they failed to adhere to the agreements. The enhanced plan offered a range of health services – such as smoking cessation, obesity management and nutritional advice programmes – not available on the basic plan. Those who signed up to the advanced plan were required, amongst other things, to “*make best efforts to stay healthy*”, “*take prescribed medicines*” and “*attend special health classes as ordered*” (Steinbrook 2006).

Around the same time, many private American insurance companies adopted aspects of the social German insurance model and many of them now routinely offer bonuses to both individuals and companies if insured patients take steps to improve or manage their health (Schmidt et al. 2010). For example, many American insurers soon required employers or employees to pay higher premiums if they smoked or if they were obese (Morreim 1995; Yoder 2002).<sup>22</sup> Blue Cross-Blue Shield Michigan, for example, provided discounts of up to 20% on deductibles and co-payments if employees agreed to adopt a healthy lifestyle (Mello 2008). Moreover, in a recent

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<sup>22</sup> The chief executive of one insurance company which offers insurance reimbursements if people achieve certain blood pressure, weight, cholesterol and tobacco avoidance targets argues that this approach is similar to driving insurance which for many years has taken risky driving behaviour into account and translated different behaviour into “*premium differences for drivers*” (Schmidt et al 2010).

study, 40% of all employers supported higher insurance premiums for employees who were obese and who refused to take part in weight loss programmes and another study found that 44% of insurance companies reported that they would charge higher premiums to people who engaged in risky behaviours (Ibid, p1919).<sup>23</sup>

It is also worth noting that the concepts of causal, moral and consequential responsibility for health have begun to have an impact on a wide range of different aspects of American life.<sup>24</sup> For example, a few decades ago it was reported that a town in Virginia refused to employ smokers as fire fighters because smokers increased the costs of health and disability insurance (Veatch 1980). An increasing number of judges also take account of the role that people play in the aetiology of their own ill-health when determining the degree of damages that should be awarded in civil negligence claims (Morreim 1995). Indeed, legal scholars in the US have noted that non-compliance with a prescribed medication regimen and other such factors can be used to reduce damages in negligence cases on the basis of the concept of “*contributory negligence*” (Barry et al 1991).<sup>25</sup>

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<sup>23</sup> In the former of these studies, 37% of employers also supported the idea of requiring obese employees to take part in weight loss programmes as a condition of being insured at all.

<sup>24</sup> The owner of a health food chain in the USA also recently praised the Erewhon novel written by Butler in the 19<sup>th</sup> century and argued that this novel which, it will be remembered, involved punishing people who were morally responsible for their ill-health, was now “*more appropriate than ever*” (McKasky 1998).

<sup>25</sup> In one such legal case the family of a recently deceased patient sued a doctor for failing to adequately manage the patient’s heart condition. The physician argued in court that the patient had effectively committed suicide because he had, for years on end, not taken his medications as prescribed and had failed to change his lifestyle – in particular, he had continued to smoke, eat unhealthy foods and had refused to exercise much. The judge in this case dismissed this argument because he argued that these causes were too remote to be “*proximate*” causes of death. However, the judge did accept that the patient’s refusal to attend medical services once his chest pain got worse – as he had been explicitly told to do – was a proximal contributing factor (Morreim 1995).

The Japanese government has also recently started to take the issue of personal responsibility for health seriously. In 2008 the government introduced legislation requiring all citizens over the age of 40 to have their waists measured annually. The new rules state that if a woman's waist measured more than 35.5 inches or if a man's waist measured more than 33.5 inches they would be referred to see a nutrition specialist for counselling and monitoring (Singer 2008).

The new legislation also enabled the Japanese government to penalise companies and local governments if more than a certain number of their employees' waists were above these thresholds. The penalty took the form of higher insurance premiums (Onishi 2008). Unsurprisingly, many Japanese companies responded to the threat of a financial penalty by introducing bonus schemes similar to the schemes introduced by the German and American health insurance organisations.<sup>26</sup>

New immigration rules recently issued by the New Zealand government state that *"applicants for visas and permits for New Zealand must have an acceptable standard of health"* because the government is concerned that admitting people with unacceptable standards of ill-health will impose significant costs on the health service of the country (Department of Labour 2008). Following the implementation of these rules, the New Zealand Immigration Service requires all applicants to undergo a thorough medical examination and, in some cases, people attempting to migrate to New Zealand have been barred from obtaining a visa on the basis of their weight (First Migration 2008).

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<sup>26</sup> Sunstar, a well known Japanese company, now sends overweight employees to a boot camp for the obese – also dubbed a "fat farm" – where employees learn, amongst other things, about the causes of obesity, good nutrition and a range of different exercise regimens (Singer 2008).



With regard to the specific issue of unhealthy food, Denmark and Hungary have led the way in trying to use legislation to change people's diets and to make people who choose to eat unhealthy food bear the costs of their choices. In 2003 Denmark became the first country to prohibit the sale of trans-fats and in 2009 the Danish government increased tax rates on unhealthy foods and drinks such as chocolate, sweets and soft drinks (Nestle 2011). Then, in 2011, the Danish government introduced a new "*fat tax*" on all foods containing more than 2.3% saturated fat (BBC News 2011). The burden of calculating the required tax (product by product) is actually placed on the shoulders of food producers, but the cost of paying the tax ultimately falls on consumers.<sup>27</sup>

Hungary also introduced its own food taxes on a range of unhealthy food products – such as soda, chocolate and crisps – in 2011. The Hungarian scheme requires people to pay a small tax of 10 forint (€ 0.037) on products that contain a "*high*" amount of fat, sugar or salt (Euractive 2011). Tellingly, the Hungarian Prime Minister, Viktor Orban, defended the new tax on the grounds that "*those who live unhealthily have to contribute more*" (Cheney 2011).

The situation in the UK is rather complex. Though Thatcher may stake a claim to have led the right wing revolution in the Anglo-Saxon world in the 1980s, her government did not implement cost bearing health policies. Nor, for that matter, did the Conservative government of Major or the Labour government under Blair and Brown. Like Thatcher, Blair championed the general importance of individual responsibility. In one speech he argued that he wished to create a society where

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<sup>27</sup> It is also worth noting that although these policies are very modern in some ways, Denmark has taxed sweets since 1922 (Euractive 2011).

*“more opportunities, and more choices, are matched by greater responsibility on the part of individuals to help themselves”* (Brown 2009). Nonetheless, there was no attempt during Blair or Brown’s time in power to alter the nature of the NHS by requiring patients to keep healthy or by penalising them for failing to do so.

Likewise, although Cameron, the current Conservative Prime Minister, agrees with the idea that personal responsibility is critical, he has shied away from allowing cost-bearing policies to change the nature of the NHS. That said, in a much quoted speech, Cameron has argued that *“refusing to use these words – right and wrong – means a denial of personal responsibility and the concept of moral choice. We talk about people being “at risk of obesity” instead of talking about people who eat too much and take too little exercise... Of course, circumstances...have a huge impact. But social problems are often the consequences of the choices that people make”* (Brown 1999). This suggests that the current Prime Minister is both aware of, and interested in, the concept of causal and moral responsibility for health and it is possible that he will attempt to put in place policies which require people to take consequential responsibility for their health in the near future.

It is also important to realise that although there was no overt attempt to change the NHS under the most recent Labour government, Blair did publish a number of policy documents which gave a central role to the idea of personal responsibility for health. These included a Department for Health report entitled “Choosing health: making healthy choices easier” and a Cabinet Offices’ report entitled “Personal responsibility and changing behaviour: the state of knowledge and its implications for public

policies” (Schmidt 2007b). Both of these were published in 2004 and caused quite a stir at the time.

Moreover, since the early 1990s, a number of Primary Care Trusts have operated what may fairly be described as cost bearing policies. As I noted in the previous chapter, a number of these Trusts refuse to carry out certain orthopaedic operations on patients who are obese whilst others stipulate that smokers will only receive elective surgical treatment (i.e. non emergency treatment) if they stop smoking for 3 months prior to the operation day (Schmidt 2007c).

The 2005 Scottish NHS Charter – entitled *The NHS and You* – also openly proclaims that patients should “*look after [their] own health and have a healthy lifestyle*” and the charter goes on to list a whole series of patient responsibilities which include the following: “*keep your appointments*”, “*follow advice and treatment*”, and “*use health services appropriately*”. Moreover, in England and Wales, the NHS Constitution states that patients should “*recognise that you can make a significant contribution to your own, and your family’s, good health, and take some personal responsibility for it*” (Department of Health 2012). The most recent Public Health White Paper 2010 also bluntly states that “*many premature deaths and illnesses could be avoided by improving lifestyles*” and that the public should take a more responsibility for their own health (Department of Health 2010).

Importantly, the Scottish NHS charter does not require health care professionals to ensure compliance with the charter, nor does it require patients to bear any costs if they fail to live up to their responsibilities. Likewise, the NHS Constitution lacks teeth

in the sense that patients who fail to abide by the Constitutions provisions face no penalty. However, these documents indicate rather nicely how the concept of personal responsibility is beginning to take hold in the UK.

### **2.3. Conclusion**

In this chapter I have argued that the concept of personal responsibility for health has a long history. I have also argued that it is only in the last century that the claim that people are causally responsible for their own ill-health has been based on a solid foundation. Moreover, I have suggested that although the notion that people are morally responsible for their ill-health has been with us for many millennia, it is only in the last few decades that politicians and legislators have begun to deploy the concept in health policies and started to require some people to bear the costs of their risky health affecting choices.

Where does this leave us now? I think that the trend is clear and, as the 21<sup>st</sup> century progresses, all manner of “responsibility for health” policies will become ubiquitous in both the developing and the developed world. These policies are also increasingly likely to involve sticks as well as carrots – meaning that cost bearing health policies are likely to come to the fore as the problems associated with risky behaviours become more common and more expensive to treat. Indeed, as I noted in the previous chapter, it is partly for this reason that a thorough analysis of cost bearing policies needs to be provided and I hope that I have now set the scene for this analysis by placing the debate about personal responsibility for health in some kind of historical context.

## Chapter 3

### Public, Patient and Professional Opinion

*“I bloody well deserve it because I knew what the outcome was.”*

– Quoted by Richardson et al (2002)

#### 3.0 Introduction

As we have seen in the last chapter, policy makers, politicians and legislators are increasingly enamoured with the concept of personal responsibility for health and they are increasingly implementing cost bearing measures too. But what do patients, health care professionals and the general public think about consequential responsibility in the health care context? Do they think that scarce livers should be allocated to patients suffering from alcoholic liver disease? Do they think that smokers should be denied access to health care? Do they think that people who consume too much saturated fat should pay some kind of risk tax?

Until very recently no one had any real idea what patients, the lay-public and most health care professionals thought about these issues.<sup>28</sup> However, over the last few decades a number of surveys and studies have been conducted to try and unearth the views of the public about these issues and a small number of studies have also explored the views of health care professionals and patients. Most of this research has been carried out in the developed world – especially in the UK, USA and Australia –

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<sup>28</sup> The views of a small handful of prominent health care professionals, like Knowles (1977) and Kass (1975), had been made abundantly clear in a series of journal articles, but the beliefs of the “silent” majority of health care professionals was not known – or sought.

and in this chapter I will discuss a small sample of the more informative studies and surveys that have thus far been conducted in these countries. However, before I launch into a discussion of the data, I will begin by saying a few words about the reasons why exploring the views of the public, patients and health care professionals is important.

### **3.1 Why bother with public, professional and patient opinion?**

Moral and political philosophers who wish to influence public policy have good reason to pay careful attention to public surveys. Politicians and policy makers have no choice but to do so. The latter must take heed because their careers often depend upon their ability to both understand and respond to public opinion. Philosophers interested in public policy must do likewise because if they fail to provide advice which is at least palatable to the lay public their counsel will be ignored and even derided by those with the power to actually create policies.

This is not to say that politicians, policy makers and philosophers must rely entirely on the pre-reflective views of the general public. As Mill (1998) argued very eloquently over a century ago, the “*tyranny of the majority*” is an ever present threat and, in many cases, public attitudes may not be a morally defensible basis for policy because they are based on prejudicial beliefs and ignorance (Attenbury 1996; Batey 1997). For this reason it is sometimes right and proper for political leaders and their philosophical advisors to challenge the views of the general public. Nonetheless, though it is important that experts and leaders do not feel entirely stymied by public opinion, it remains the case that those who devise policy – and those who seek to

influence this process – must reflect the views of the citizenry to some extent. For, if they do not, their policies will lack a proper democratic mandate and will probably be rejected by the demos.

There are also good reasons for philosophers, politicians and policy makers to pay particular heed to the views of health care professionals *qua* professionals. This is because these individuals are uniquely placed to provide information about the feasibility of implementing health care policies. Health care professionals have an excellent understanding of how health care services work, how easy or difficult it would be to implement new policies and the likely impact that policies will have on patients, staff and the health care system as a whole. It would be very unwise, therefore, to try and devise and implement health policies without listening carefully to the people who effectively run the system.

Moreover, without the support of health care professionals no health care policy is likely to be implemented successfully. There are two reasons for this. Firstly, health care professionals represent a powerful lobby group and they can do much to derail health care policies by either directly influencing government ministers or by appealing to the media and the general public. Secondly, if a health care policy is pushed through in the teeth of serious opposition from health care professionals, these same health care professionals will be in a powerful position to sabotage the policy once it is implemented. Health care professionals rarely put down the tools of their trade and take direct industrial action. This is because of the deleterious impact this would have on patients. Nevertheless, they can easily take more subversive actions and thus undermine a policy in a more in-direct way.

Patients *qua* patients do not have any special knowledge about philosophical concepts or special skills in the health care policy arena. Moreover, their knowledge of the health care system is usually less systematic and thorough than the knowledge of health care professionals. Consequently, it might not seem obvious why the views of patients should be sought when health policy is being decided.

However, there is at least one reason why this would be a very good idea. This is because patients have a deeper understanding of the likely effects that health care policies actually have on other patients. People who have never been seriously or chronically ill can have little understanding of the degree of physical, psychological and financial damage that serious and or chronic illness can have. Admittedly, health care professionals and relatives often have some degree of insight into these matters, but it is patients who ultimately bear the brunt of ill-health and it is they who will be most affected when health policies change. Thus, I would argue that patients – especially those who are either chronically ill or who have recently recovered from a serious acute illness – can provide a particularly clear insight into the effects that various health care policies might have and should be consulted for this reason.

### **3.2 The public's views of responsibility for health and cost bearing**

Editors and columnists have been venting their frustration for many decades about the burden placed on tax payers by people who “wantonly” fail to take care of their health and politicians have been advocating responsibility-sensitive cost bearing policies for many years now (Cappelen and Norheim 2005). This very much suggests that a significant number of lay-people living in developed countries support the idea that



some people should be made to bear costs if they choose to engage in risky health affecting behaviour. After all, journalists and politicians would not have spent so much ink and political capital on a subject that only a small minority care about.

However, though we can infer from all these editorial pages and political speeches that many lay-people support the concept of consequential responsibility these sources do not tell us exactly how popular this concept really is. Nor do they tell us why people believe that people who take risks with their health should bear costs or what form most people think cost bearing policies should take. Fortunately, a number of researchers have recently made a concerted effort to elicit the views of the general public about the role that responsibility should play in the allocation of scarce health care resources and, to a lesser extent, about their views on cost bearing in relation to health care. Most of this research has taken the form of basic public surveys, but a number of more detailed research studies have also now been carried out and we now have a reasonably detailed picture of what people think about these issues.

The first set of surveys designed to elicit the view of the lay public about health care policies were rather simplistic. Most of them simply asked respondent's one highly specific responsibility-related question: whether people who took certain risks with their health should bear a cost by receiving lower priority if they subsequently needed health care. Nonetheless, the results of these surveys demonstrated that a significant number of people answered this question in the affirmative. For example, a Swedish study reported that 50% of respondents thought that people who take care of themselves should receive priority for their health over those who did not take such care, whilst a study in Wales found that 41% of respondents thought that people who

fail to what they can do remain healthy should be given a lower priority for treatment (Braakenheilm 1990; Edwards et al. 2003).<sup>29</sup>

The results of these surveys were not especially informative because they did not explore people's reasons for making people bear costs in much depth. However, they did give researchers an indication that about half of all lay respondents believed that people should bear some sort of cost (i.e. lower priority for health care) if they engaged in certain types of risky health affecting behaviours. This encouraged other researchers to design more complex surveys and studies which enabled more in-depth data to be gleaned about the lay public's beliefs, values and preferences in relation to the issue of consequential responsibility for health.

One of the first detailed studies conducted in this area was carried out by Ubel *et al* (1999). Ubel and his colleagues randomly allocated one of five different "*patient scenarios*" to 283 prospective jurors in the state of Pennsylvania. In each of the five scenarios the respondents were asked to decide how they would distribute 100 hearts for transplantation between two different groups of 100 hypothetical patients who either had or had not engaged in a risky health affecting behaviour in the past. The five scenarios differed from each other on the basis of the prognosis of the patients,

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<sup>29</sup> A more sophisticated survey carried out by Bowling (1996) discovered that 42% of respondents agreed or strongly agreed with the claim that "*people who contribute to their own illness – for example through smoking, obesity, or excessive drinking – should have lower priority for their health care than others*". The Oregon Health Services Commission also uncovered some interesting information about people's attitudes towards personal responsibility for health. The Oregon legislature asked the citizens of Oregon to rank 714 condition-treatment pairs in order of priority and when the results were analysed it was found that the people of Oregon had ranked "transplantation for alcoholic liver disease" at number 695, whereas "transplantation for liver disease not related to alcohol" was ranked at number 364 (Dixon and Welch 1991).

the nature of the risky health affecting behaviour that the patients engaged in and whether the risky health affecting behaviour caused the patient's organ failure. At the end of the study respondents were also asked to justify their allocation decisions.

The results of the study were very revealing. The majority of respondents were less willing to give organs to people who had engaged in a risky health affecting behaviour than those who had not (Ibid, p 62). For example, respondents were less willing to allocate organs to smokers than non-smokers and they were also less willing to allocate organs to patients with a history of intravenous drug abuse than to patients who had not taken intravenous drugs in the past. They were also less willing to allocate organs to patients who ate high fat diets than to patients who did not.

However, it was also discovered that respondents were significantly less willing to give organs to patients who were intravenous drug users than to patients who were smokers or to people who had a high fat diet. This was true even when the patients who were intravenous drug abusers had a better prognosis than patients who were smokers or had a diet which was high in fat. Respondents were also statistically just as unlikely to give organs to patients whose risky behaviour had caused their heart failure as they were to patients whose risky behaviour had not caused their heart failure.

The justifications given by those respondents who gave less than 50% of the organs to patients who engaged in risky health affecting behaviours were later organised and classified (Ibid, p 63). The most common rationale proffered by the respondents who had allocated decisions in this way was simply that "*people who cause their own*

*illness should not receive equal priority for treatment*".<sup>30</sup> 21% made this claim where the risky behaviour was a high fat diet, 31% made the claim where the risky behaviour was smoking, and 28% made the claim where the risky behaviour was intravenous drug use. 15% also claimed that the reason why they gave less than 50% of the organs to who had taken was because the risky behaviour was "*socially unacceptable*". 7% made this claim in relation to a high fat diet, 9% in relation to smoking and 21% in relation to intravenous drug use.

What are we to make of these results? The most obvious point is that a substantial number of respondents in this study made (hypothetical) allocation decisions on the basis of some notion of personal responsibility for health and they were also willing to make some patients bear the costs of their risky health affecting behaviour. This confirms the results of the earlier surveys which suggest that a significant number of people believe that the concept of consequential responsibility should apply in the case of risky health affecting behaviours.

The second important point is that the results show that many respondents treated smokers, intravenous drugs abusers and people who ate a high fat diet differently. Ubel et al (Ibid, p 65) claim that this could be explained by the fact that certain risky behaviours are less socially unacceptable than others. But multiple explanations are possible. For example, respondents may have regarded all three types of risky health affecting behaviour as immoral and deserving of some kind of penalty, but regarded

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<sup>30</sup> This classification included people who claimed that patients should "*suffer the consequences of freely made choices*" and also people who claimed that "*patients had a personal responsibility to avoid these behaviours*" (Ibid, p 63).

drug abuse as intrinsically morally worse than either smoking or eating a diet high in fat.

On the other hand, it is possible that respondents perceived drug abuse to be more dangerous than smoking or eating a diet high in fat and thus wished to penalise drug abusers more for reasons relating to deterrence. In reality, it is likely that different respondents based their decisions on the basis of different values, but it is difficult to know for sure because the questions asked by the researchers did not unpick these issues.

The third thing to note is that the data proves that some respondents were not making allocation decisions purely on the basis of future outcomes. This is because at least some respondents were less willing to give organs to patients who were intravenous drug users than to smokers or patients who consumed too much saturated fat – even in scenarios where the drug users had a better prognosis. This is important because it is sometimes suggested that the reason why people don't allocate organs to those who are responsible for their ill-health is because they assume that people who are ill for this reason have a worse prognosis.

The fourth and final point to note is this. A number of respondents claimed that people should receive lower priority just because they *caused* their own ill-health. However, as Ubel et al (Ibid, p 63) note, some of those who made this claim treated smokers, drugs addicts and people who consumed too much fat differently. Moreover, it was found that causality was not a statistically significant factor in patient's allocation decisions even though 27% of people justified their decisions on the basis

of causal claims alone. This means that there was some contradiction between the rationale people gave and the actual choices that they made.

Quite why this happened is not clear. One possibility is that respondents wanted to believe that they were making allocation judgments on some kind of “empirical” rather than “moral” basis, but were influenced by moral considerations when they actually had to make choices. Indeed, Ubel et al (Ibid, p58) argue that these results give us good reason to be very wary of relying on what people say when we try to determine people’s true motivations for defending cost bearing policies. They also add, on the basis of this evidence, that arguments in favour of personal responsibility for health may be a convenient way to hide judgements based on social desirability. However, we should bear in mind that people may simply have made mistakes when describing their reasons for making judgments. In other words, many people may have been quite willing to own up to their moralistic judgments but lacked the vocabulary to do so and so plumped for the “causal” rationale instead.

The other major study conducted by Ubel et al. (2001) on the issue of personal responsibility for health also involved prospective jurors in the United States. In this study prospective jurors were asked to read four different scenarios and complete a written questionnaire about them. In each scenario the respondents were required to allocate 100 organs between two groups of 100 patients. In each of the four scenarios patients in one of the groups were always described as having a history of unhealthy behaviour (either smoking or alcohol consumption) that was linked with worse transplant outcomes. In two of the scenarios the behaviour was described as being the cause of the organ failure that necessitated the transplantation whereas in the other

two scenarios the behaviour had no causal role. Respondents were also asked at the end of the study to justify their allocation decisions.

400 of the prospective jurors completed the questionnaire. On average 66% of respondents distributed organs to patients who had no history of unhealthy behaviours and 44% distributed organs to patients who did have a history of unhealthy behaviours (Ibid, p 603). Respondents also allocated fewer organs to patients whose behaviour had caused their ill-health as opposed to people who had engaged in similar behaviour but whose behaviour had not caused their ill-health. For example, patients who needed a liver transplant because of their alcohol consumption and patients who needed lung transplants because of their smoking habit were allocated fewer organs than patients who drank alcohol or smoked but whose risky behaviour did not cause their organ failure.<sup>31</sup>

In justifying their various allocation decisions a significant number of people who gave more organs to those who did not take risks claimed that they did this on the basis that patients in these groups were “*personally responsible for their health*” (Ibid, p604). A significant number of people who refused to distinguish between people in this way argued that they did not do this because “*people should not be punished for past wrongdoings*” (Ibid, p605).

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<sup>31</sup> Interestingly, it was also discovered that respondents who had never smoked were less willing to distribute lungs to patients who had a history of smoking than respondents who had smoked in the past. Respondents who had previously smoked, meanwhile, were less willing to distribute lungs to patients who had a history of smoking than respondents who currently smoked.

The results of this study demonstrate once again that some people are willing to make people bear costs if they engage in risky health affecting behaviours in certain situations. The study also suggests that whether patients actually cause their ill-health seems to matter to some people when they make resource allocation decisions on the basis of responsibility considerations. This contradicts the finding in the previous study which suggested that people were just as likely to give people lower priority to patients whether their risky behaviour caused their ill-health or not. Some of the reasons given by the respondents for their allocation decisions also suggest that some people view some risky health affecting behaviours as immoral in some sense. For example, many of the people who actually opposed the idea of consequential responsibility were quite happy to argue that engaging in some forms of risky behaviour involved some kind of “*wrongdoing*” – it’s just that they did not want to penalise them for this wrongdoing.

The next major study that I wish to discuss was carried out by Neuberger et al (1998). In this study 1000 members of the general public, 200 family doctors and 100 gastroenterologists were asked about how they wanted scarce livers to be allocated. These medical and lay respondents were each given case histories detailing eight potential donor recipients. These eight potential donor recipients differed from each other on a number of counts, but three were causally responsible for their ill-health whilst the other five were not. The respondents were then asked to decide which four of these eight recipients should receive the four donor livers which were available for transplantation. They were also asked to indicate which case was the least deserving



case and which of seven possible factors should be used to determine which patients already waiting for transplantation should get a transplant.<sup>32</sup>

The key results of this study are as follows. Firstly, a majority of the lay public gave the (hypothetical) patients who were causally responsible for their ill-health (i.e. the ex-drug abuser, the alcoholic and the patient who overdosed on paracetamol) lower priority in the allocation of scarce organs than all the other patients bar the patient who was a prisoner (Ibid, p 173). This was true even when the prognosis of some of these patients was worse than the prognosis of patients who were not causally responsible for their ill-health. Indeed, only 16% of the general public gave one of the four available livers to the alcoholic, only 17% gave a liver to the ex drug abuser and only 47% gave a liver to the patient who had taken an overdose. Family doctors and gastroenterologists also gave the patient who was an alcoholic lower priority than all the other patients (other than the prisoner), but they were far more willing to give livers to the drug abuser and the patient who had taken an overdose – probably because these patients had a much better prognosis than some of the other patients.

The patient with liver disease was also selected as the “least deserving” of all eight patients by 33% of the general public, 40% of family doctors and 33% of gastroenterologists (Ibid, p 173). Only the prisoner fared worse. The results were more mixed in relation to the other patients who had caused their own ill-health although the general public regarded the drug abuser as less deserving than any of the patients other than the alcoholic and the prisoner.

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<sup>32</sup> The seven factors were: outcome, time on waiting list, value to society, previous use of illicit drugs, age, return to work, and involvement of alcohol in their liver damage (Ibid, p 173).

Finally, 28% of the general public, 41% of family doctors and fully 68% of gastroenterologists claimed that alcohol consumption was one of seven factors that should be used to help determine how donor livers should be allocated (Ibid, p 174). This reflected their view that patients whose liver disease was unrelated to alcohol should be given a higher priority than those who had alcohol related disease. 30% of the general public, 36% of family doctors and 36% of gastroenterologists also argued that they would regard drug taking or overdose as a factor that should be used to determine how donor livers should be allocated. This reflected their view that patients whose liver disease was unrelated to drug taking and overdose should receive higher priority than those whose liver disease was related to these behaviours.

The results of this study are interesting for a number of reasons. Firstly, they once again demonstrate that the lay public (and health care professionals) are sometimes willing to take considerations of responsibility into account when determining the allocation of scarce resources. Secondly, the results suggest that doctors and the lay public are equally likely to argue that patients who are causally responsible should bear costs at least in cases where prognosis is not an over-riding issue. But, when prognosis is poor, doctors tend to ignore responsibility issues whilst the lay public take a different view – suggesting that responsibility should still be a major factor in determining the allocation of scarce organs. This suggests, though it does not prove, that doctors make judgments about responsibility and cost bearing on the basis of a more utilitarian calculation than the lay public who may be more willing to make judgments on the basis of moralistic-desert claims.

Thirdly, although a majority of respondents regarded people with alcohol induced liver disease as less deserving than other patients they did not think the same about people who had developed liver disease as a consequence of taking an overdose or from having taken drugs – though the general public were still quite likely to regard drug users as less deserving. This is curious because people who damage their livers by taking an overdose or by taking drugs are just as causally responsible as people who damage their livers by consuming too much alcohol. It may be that the explanation in this case has something to do with people's perceptions of moral responsibility.<sup>33</sup>

Another explanation is that some people think that being an alcoholic is morally worse than being an ex-drug user and morally worse than trying to commit suicide. Alternatively, people might think that the deterrent effect of denying treatment to alcoholics will be more effective than in the other cases. However, this last explanation is somewhat undermined by the fact that people used the language or “desert” in this instance.

Wittenberg and Fischhoff (2003) also conducted a major study looking at lay people's rationing allocation choices in situations where patients are regarded as responsible for their ill-health. Their study is especially interesting because, having recorded people's original opinions, they explored the effect that different ethical arguments had on people's choices. The study was conducted in the United States and 310 people completed the questionnaire.

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<sup>33</sup> It is possible that people regard alcoholics as more morally responsible than ex-drugs users and people who take an overdose.

The study centred on two scenarios involving groups of patients who were competing for scarce resources. The groups differed in the sense that patients in some of the groups suffered from diseases that they were causally responsible for whilst people in other groups suffered from diseases they were not causally responsible for. In one scenario, patients with liver disease caused by alcohol consumption were contrasted with patients with liver disease caused by an inherited condition and in the other scenario patients suffering from asthma caused by “in-the-home” air pollution were contrasted with patients suffering from asthma caused by “outdoor” air pollution (Ibid, p 195). Respondents were required to allocate scarce health care resources between the group of patients with liver disease caused by alcohol and the group of patients with liver disease caused by an inherited factor. They were then asked to do the same with the two asthma groups.

Once they had made their decisions the respondents were asked to read a number of statements about different ethical arguments relating to resource allocation. They were then asked to repeat the allocation process for the four groups of patients in order to determine whether reading about the arguments affected the way they allocated resources between the groups. Finally, the respondents were asked to explain their decision making reasoning “*in their own words*” (Ibid, p196).

In both the alcohol and the asthma scenarios respondents allocated fewer resources to the groups of patients who were deemed responsible for their health. Interestingly, however, reading and discussing statements about various ethical arguments did not change most people’s opinions. Before reading about these arguments 35% of respondents did not allocate any livers to the patients with alcoholic liver disease,

36% allocated fewer livers to this group and 27% allocated the livers equally. The respective results after reading about the ethical arguments were as follows: 33%, 40% and 27% (Ibid, p200).<sup>34</sup>

Similar results were found in the asthma scenario, although respondents were more willing to allocate resources to patients who had developed asthma as a result of their own behaviour. 17% of respondents did not allocate any asthma treatment to patients with asthma caused by “in-home pollutants”, 21% allocated fewer resources to patients with asthma caused by “in home” pollutants and 52% allocated treatment equally. After reading and discussing the ethical arguments the respective results were as follows: 21%, 23%, 47% (Ibid, p198).<sup>35</sup>

Wittenberg and Fischhoff (Ibid, p 200) classified respondent’s rationales for their allocation decisions into 14 different reasons in the case of asthma treatments and 17 different reasons in the case of liver treatments. The primary reason why people decided to allocate fewer resources to patients with asthma caused by indoor pollution was because these patients could “*control*” this form of pollution. The main reasons people gave for allocating fewer resources to people with alcohol induced liver disease was because “*alcohol consumption is voluntary*” and because “*alcoholics are responsible for their ill-health*” (Ibid, p 200).

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<sup>34</sup> None of the respondents allocated more livers to the patients with alcohol liver disease than to the patients with inherited liver disease either before or after reading the ethical arguments.

<sup>35</sup> In this case 10% allocated more resources to those with asthma caused by “in home” pollution and 2% allocated all the resources to those with asthma caused by “in home” pollution. These figures did not change much after respondents had read the ethical arguments.

Three things stand out about these results. Firstly, a significant number of people were more willing to allocate resources to people who had diseases which were (in some way) caused by their own behaviour. Again, this confirms the results of previous studies. Secondly, respondents were much more likely to make use of the concept of consequential responsibility in the case of alcohol induced liver disease than in the case of asthma caused by indoor pollutants. This may reflect the fact that drinking alcohol is seen by many to be an intrinsically immoral behaviour whereas the behaviours that are responsible for “indoor” pollution (whatever they might be) may be not be regarded in the same light. Alternatively, it may be that utilitarian considerations were once again playing a role.<sup>36</sup>

Thirdly, people’s decisions about how to allocate resources hardly changed at all after they had been asked to read and deliberate about a range of ethical rationales as to why and how resources should be allocated. Wittenberg and Fischhoff (Ibid, p 201) responded to this latter finding by claiming that “*rationing preferences may be sufficiently formed that others opinions have little influence over them*”. However, we should bear in mind that other studies have suggested that people’s rationing preferences can be modified if they are given further information. There is also evidence to suggest that people are less likely to hold people consequentially responsible once they have analysed these ethical arguments in more depth (Nord et al 1995).

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<sup>36</sup> In other words, people may well have believed that alcohol consumption is more dangerous than indoor pollutants and thus wanted to penalise alcohol consumers more heavily in order to create a stronger deterrent effect.

### 3.3 Health care professional's views of responsibility for health and cost bearing

A very small number of health care professionals have made their views about consequential responsibility very clear. Knowles (1977), as we have seen, helped to start this trend over four decades ago and hundreds of short articles have now been published by health care professionals either opposing or defending health policies which are centred on the concept of personal responsibility for health. However, health care professionals who have written articles about this issue are not a very representative sample of health care professionals as a whole and there is a real shortage of data about what most health care professionals think about the concept of responsibility-sensitive cost bearing policies.

To an extent we can infer something about what many health care professionals believe from the official positions adopted by organisations that represent these professionals. This is because many of these organisations try to adopt positions that are based on the views of the majority of their members. Interestingly, if we look at what most of these health care organisations officially have to say about the issue of consequential responsibility for health we find a pretty robust set of statements claiming that patients should not be made to bear costs by being denied treatment or by being given lower priority for treatment on the ground that they are responsible for their ill-health.

The General Medical Council (2006) in the UK explicitly informs doctors that “*you must not refuse or delay treatment because you believe that patients’ actions have contributed to their condition*”. The UK Nursing and Midwifery Council (2004)

concur and, in its guidance, it notes that nurses and midwives must promote and protect the interests and dignity of patients “*irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or cultural beliefs*”. The Health and Care Professions Council (2012) – an umbrella body which regulates physiotherapists, radiographers and a whole array of other health care professionals – also states unequivocally that “*lifestyle*” factors should not affect the way patients are treated.

The American Medical Association (1997) takes a similar line in relation to organ transplants and reminds American doctors that “*the contribution of the patient to his or her medical treatment*” should not be used as a selection criteria for organ transplantation decisions. Moreover, the World Health Organization (1991) adamantly proclaims that considerations of personal responsibility for health should not play a role in determining how scarce organs are allocated.

However, a number of health care organisations do agree that the concept of personal responsibility should play a much more dominant role in healthcare than it currently does. The British Medical Association (2007) recently called for an NHS charter that would set out the rights *and* responsibilities of patients.<sup>37</sup> The American Medical Association (1993) has also put forward a list of what it called “*patient responsibilities*” – which included the responsibility of patients to ensure that they

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<sup>37</sup> A large majority of delegates at the British Medical Association’s annual representative meeting in 2007 also voted in favour of a charter that “*focuses on the individuals responsibility both in health and illness*” (Schmidt 2007a).



attend appointments, adhere to medical regimens, and take measures to improve and maintain their health.<sup>38</sup>

Importantly, neither the British Medical Association nor the American Medical Association defended the idea that people should bear costs for their choices by being denied treatment, but there can be no doubt that these organisations take the concept of personal responsibility very seriously and they clearly think that patients need to do more to help themselves. Furthermore, many health care organisations strongly advocate placing higher levels of commodity taxes on alcohol and cigarettes and some of them also defend the idea of placing taxes on other products too. Consequently, there is some agreement that some forms of cost bearing are both reasonable and defensible.<sup>39</sup>

In order to get a better grasp of what most health care professionals think about these issues what is needed is a series of in-depth surveys. Unfortunately, few such surveys have ever been carried out. The study carried out by Neuberger et al (1998) did try to find out what a small sample of gastroenterologists and general practitioners thought about these issues, but the only major survey which focused entirely on eliciting the views of health care professionals is the one carried out by Brinegal and Feiring

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<sup>38</sup> Importantly, the rationale provided for these recommendations refer to the benefits that taking such steps would have in maintaining health. At no point does the American Medical Association recommend taking sanctions against patients who fail to live up to their responsibilities (Kelley 2005).

<sup>39</sup> We must also remember that although these health care organisations try to represent the views of the majority of the professionals it is difficult for them to be sure what the rank and file really think about these issues.

(2008) which collected data from 1072 respondents who replied to a Norwegian Doctors Survey.

This survey was very wide ranging and covered many issues unrelated to the topic of responsibility for health. However, the survey did ask participants to answer two questions relating to the concept of personal responsibility for health. The first question asked doctors about the strength of their agreement and disagreement with five statements each of which related to the issue of personal responsibility for health. The second question asked doctors whether they thought that any (of a list of nine) risky health affecting behaviours should influence priority for health care. The five statements and the nine risky behaviours can be found, along with the results of the study, in Figures 2.0 and 3.0 below.

**Figure 2.0. Agreement with Statements about Personal Responsibility – adapted from Brinegal and Feiring (2008, p 359).**

	<b>Disagree Completely</b>	<b>Disagree Partly</b>	<b>Neutral</b>	<b>Agree Partly</b>	<b>Agree Completely</b>
<b>Health care priority should depend on the patient's personal responsibility</b>	24.1%	33.0%	25.9%	15.9%	1.2%
<b>Access to expensive treatment should depend on the patient's personal responsibility</b>	23%	32.6%	25.3%	22.7%	2.8%
<b>Access to scarce organ transplants should depend on the patient's responsibility</b>	20.8%	28.6%	23.8%	22.7%	4.2%
<b>Lower priority should be allocated to patients who violate a contract of changes in lifestyle</b>	18.4%	31.3%	26.3%	21.1%	2.9%
<b>A patient who is responsible for the disease should pay additional co-payments</b>	43.0%	30.9%	18.6%	6.5%	1.0%

**Figure 3.0. Types of Risk Behaviour that Should Count in a Priority Situation – adapted from Brinegal and Feiring (2008, p 359).**

	<b>Yes</b>	<b>Don't Know</b>	<b>No</b>
<b>Poor Quality Nutrition</b>	14.9%	14.9%	70.2%
<b>Lack of Physical Exercise</b>	20.8%	16.4%	62.8%
<b>Combination of the factors</b>	25%	21.6%	53.4%
<b>Overweight/obesity</b>	26.7%	16.3%	56.9%
<b>Violation of contract leading to injury/disease</b>	27.1%	17.9%	55%
<b>Drug Abuse</b>	34.4%	14.7%	50.9%
<b>High risk sports leading to injury/disease</b>	35.3%	16.2%	48.5%
<b>Excessive alcohol consumption</b>	37.7%	13.8%	48.5%
<b>Smoking</b>	44.0%	10.9%	45.1%

The first thing to note about the results is that the majority of Norwegian doctors who responded to the survey did not agree that the issue of personal responsibility for health should influence resource allocation decisions. However, the study does show that a significant number of doctors believed that some patients should bear the costs of their risky health affecting choices. For example, 17.2% doctors partly or strongly agreed with the statement that *“healthcare priority should depend on the patient’s personal responsibility for the disease”* and 26.9% partly or strongly agreed with the claim that *“access to scarce organ transplants should depend on the patient’s personal responsibility for the disease”* (Ibid, p 359). 25% of the respondents also considered that information about various risk factors is relevant when it comes to considering how priority decisions should be made and this figure rises to 37.7% and

44% in the case of excessive alcohol consumption and smoking respectively (Ibid, p 359).

The study also tells us that some doctors, just like the members of the general public in other studies, tend to treat people who take different kinds of risks in a different ways. For example, in this survey many Norwegian doctors were more likely to defend the idea that people who caused their own ill-health as a consequence of smoking, drinking alcohol or abusing drugs should bear costs than they were to defend cost bearing in relation to patients who did not exercise regularly or were overweight (Ibid, p 360). The results also demonstrate that the respondents were far more comfortable with the idea of making patients bear costs by receiving lower priority for treatment than they were with patients being made to bear costs by providing additional payments (Ibid, p 360).

Unfortunately, this survey did not explore why so many doctors believed that patients should bear the costs of their health affecting choices. Nor did the survey explore the reason why these doctors wanted to treat people who engaged in different kinds of risks differently. Feiring and Bringeal (Ibid, p 360) postulate that one reason why the doctors in the study wanted people to bear the costs of their choices is because they believed that some risky health affecting behaviours are, in some sense, immoral. They also suggest that the reason why some risky health affecting behaviours (e.g. drug addiction) were more likely to be targeted was because these kinds of behaviours “*trigger moralistic reactions*” whereas other risky behaviours, such as the decision not to exercise regularly, do not (Ibid, p 360).

This, however, is a matter of speculation and since all the results could be explained by utilitarian reasoning rather than any kind of appeal to some concept of desert it is impossible to be sure what the real explanation for these results is.<sup>40</sup>

At this point in time, then, we cannot be sure what most health care professionals think about the concept of personal responsibility or what they think about cost bearing in relation to risky health affecting behaviours. Moreover, though we do now have some limited evidence to suggest that some doctors think that patients should bear some costs we have very little information about the form that these doctors think cost bearing should take. We are equally in the dark about the normative reasons that health care professionals rely upon to defend claims about consequential responsibility. However, we do now know that some health care professionals believe that some patients should bear costs and we have some reason to think that the number of health care professionals who believe that this should happen is relatively large.<sup>41</sup>

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<sup>40</sup> This study is of particular interest because Norway is characterised by an extremely egalitarian distribution of income and the Norwegian Patient's Rights Act explicitly notes that considerations of responsibility should not be considered when doctors or health care managers decide how to prioritise the allocation of health care resources (Ibid, p 360). If about a quarter of doctors in a country as committed to egalitarian principles as Norway support some notion of consequential responsibility it seems quite likely that doctors working in less egalitarian countries will be even more supportive of such ideas.

<sup>41</sup> There is a particular shortage of information about what health care professionals who are not doctors think about these issues.

### **3.4 Patients views about responsibility for health and cost bearing**

We know very little about what most lay people and health care professionals think about the concepts of causal, moral and consequential responsibility for health, but we know even less about patients views on these matters. Given that responsibility for health policies are likely to impact this group more than any other this is somewhat surprising, but the voice of the patient is often lost in health policy discourse and it seems that the same thing has happened in relation to the debate about responsibility for health. Indeed, the only study that has successfully elicited patient's views about responsibility for health is the study carried out by Richards et al. (20003) – and even this study was not intended to deal with the issues of moral and consequential responsibility as such.

This study consisted of a series of qualitative interviews with patients who had experienced chest pain and the primary goal of the research was to determine patients' perceived causes of their chest pain and their responses to their symptoms. The interviews were semi structured and patients views about the concept of personal responsibility and self-blame were explored if they were raised by the patients themselves.

The results of this study showed that a majority of respondents had a basic understanding of the causal associations between risky health affecting behaviours and cardiac disease. In fact, "*risky behaviour*" was also cited as one of the most common reasons why patients felt that they were at risk of developing cardiac disease

(Ibid, p712).<sup>42</sup> The study also revealed some other interesting data about patient's views of the concepts of moral and consequential responsibility. For example, a substantial number of patients during the course of their interview alluded to the fact that people were "*personally responsible*" for their cardiac conditions and that people should "*blame themselves*" for developing these diseases (Ibid, p 713).

Two men in the study who had been diagnosed with coronary heart disease and Chronic Obstructive Pulmonary Disease (COPD) made very explicit reference to these ideas in relation to their own health.<sup>43</sup> This first of these men, when asked whether he had been "*unlucky*" with his health, replied: "*I don't know about that. You only get what you deserve*" (Ibid, p173). The second man responded to the same question as follows: "*Well, I have probably abused myself and I am paying for it now*" (Ibid, p173). Another woman suffering from COPD also noted that although she had realised that her disease was caused by smoking she had continued to smoke and she went on to say of her condition that "*I bloody well deserve it because I knew what the outcome was*" (Ibid, p173).

Some patients also believed that because they were responsible for their ill-health physicians would be unwilling to help them. A number even claimed that they had been made to feel guilty by physicians in the past because of their risky behaviours. Still others argued that they were reluctant to present with symptoms because they feared being reminded about their responsibilities and their unhealthy behaviours.

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<sup>42</sup> The risky behaviours most frequently cited were, in order of frequency, smoking, diet, being overweight and lack of exercise (Ibid, p712).

<sup>43</sup> As I will explain in the next chapter both of these diseases are caused by smoking in most cases.



Quite a few respondents also observed that health care professionals had threatened to withdraw care unless they changed their behaviours. One of these patients said that once he had explained to his doctor that he was still smoking the doctor responded as follows: *“There is your medication. The prescription’s made out to you. But if you’re smoking next month don’t bother comin’, you’ll get nothing from me”* (Ibid, p 174). A few patients even argued that their physicians were quite justified in giving up on them since doctors did not have a duty to help those who would not help themselves (Ibid, p 174).

These results suggest that a significant number of the patients realise that certain behaviours are risky and can cause disease. They also show that many patients believe that the concept of personal responsibility for health is already being used by health care professionals in the UK to determine if care is going to be provided. It is also salutary to note that some patients agree that this is both right and proper.

The study also suggests that many patients couch the concept of responsibility for health in the moralistic language of blame and desert and believe that people should bear costs because they deserve to do so. Moreover, as Richardson et al. (Ibid, p 715) argue, patient’s beliefs about personal responsibility, desert and self blame were, at least in some cases, either reinforced or created by health care professionals. This provides us with in-direct evidence that at least some health care professionals allow the concept of responsibility for health to influence their practice even though the General Medical Council and many other similar organizations explicitly forbids doctors from treating their patients differently on the basis of their lifestyle choices.

Further work is needed to determine what most patients actually think about the concepts of causal, moral and consequential responsibility. We cannot rely on the results of one study – especially one that was not even focused on the concept of responsibility for health – to draw conclusions about what patients *qua* patients think about these matters. In particular, further research is needed to determine whether patients make exceptions for certain kinds of activities (e.g. unprotected sex with the purpose of having children) and why they think people should bear costs if they take risks with their health. Nonetheless, the study does give us limited reason to believe that some patients defend the idea of cost bearing and that some would be willing to abide by such a policy even when they would have to bear the costs themselves.

### **3.5 Conclusion**

The data discussed in this chapter suggests that a number of patients, health care professionals and lay people believe that considerations of personal responsibility for health are important and that a significant number also believe that some patients should be made to bear the costs of their risky health affecting choices.

Far more research needs to be carried out in this area to determine people's real attitudes and to explore the reasoning behind their beliefs so that we can get a better idea about whether there exists a democratic mandate for cost bearing policies. In particular, it would be useful to know what people think about the nature and existence of moral responsibility for ill-health and exactly which normative rationales are being appealed to when people claim that those who are causally and/or morally responsible should bear some kind of health costs. It would also be very useful to find out whether health care professionals, patients and lay-people would be more or less

likely to defend cost bearing if the nature of the cost took the form of a risk tax or risk insurance premium rather than a lower priority for healthcare or some other cost which would actually cause physical harm. I suspect that this would be the case, but there is no data to actually prove this claim as things stand.

It is also worth bearing in mind that in most of the studies carried out thus far, those who think that people ought to be held responsible for their health are often in a minority (Wikler 2002).<sup>44</sup> Indeed, by searching the data so carefully for evidence of beliefs that support consequential responsibility I may have inadvertently played down the fact that a significant number of people – and in some cases a majority – do not think that personal responsibility should play a role in allocation health. However, there is sufficient data available to suggest that the concept of consequential responsibility is growing in popularity and that many patients, health care professionals and lay-people would now support some form of responsibility-sensitive cost bearing policy in relation to risky health affecting behaviour.

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<sup>44</sup> For example, in the Norwegian study described above most doctors disagreed with the idea that people who take risks should be made to bear costs.

## Chapter 4

### Causal Responsibility for Health

*“It is now a truism that actions which individuals could take on their own could be vastly more effective in combating illness than all that doctors can do.”*

– Daniel Wikler

#### 4.0 Introduction: Is health within our causal grasp?

In order to defend the idea that people should be made to bear the costs of their risky health affecting choices it first needs to be established that human behaviour does, in fact, play a causal role in the aetiology of some illnesses and injuries. We also need to establish that a reasonably significant amount of the global burden of disease is caused by human behaviour. This is because the whole debate about consequential responsibility will become something of an “academic” exercise if only a small amount of ill-health is caused by human behaviour.

My goals in this chapter, then, will be two twofold. Firstly, I will try to demonstrate that there is good reason to believe that human behaviour can cause ill-health and secondly I will try to demonstrate that human behaviour causes a significant amount of ill-health. As I noted in the first chapter, I will not attempt to analyse all the causal associations that may exist between human behaviour and ill-health here. Nor will I discuss all the evidence that has been mustered to prove that the associations that I will discuss in this chapter are casual in nature. Instead, I will provide an overview of what most health care professionals, biomedical scientists and epidemiologists think

are the most important behavioural causes of ill-health and I will provide an overview of some of the most important empirical evidence that has been marshalled to defend these claims.

#### **4.1 Correlation, causation, confounding variables, multiple-causation and proofs**

Before launching into an analysis of the causal role that human behaviour plays in the aetiology of disease a few words of caution are needed. The first word of caution relates to the issue of how sure we can be certain behaviours cause ill-health. It is sometimes very obvious that a causal association exists between some behaviour and ill-health. For example, we can confidently claim that handling very hot objects will cause burn injuries. However, most of the causal associations between human behaviour and ill-health are not easy to determine because the number of confounding variables is so high and, in these situations, we are ultimately reliant on intricate statistical analysis of complex data to make causal claims.

Nonetheless, most of the associations between behaviours and ill-health that I will discuss in this chapter are associations for which there is significant amount of evidence of causality and a widespread consensus amongst experts about the causal nature of the associations in question. Thus, although I will not discuss the issue of probability here, I want to make it clear at this stage that we have good reason to believe that the behaviours that I will discuss below cause the diseases that they are associated with.

The second word of caution relates to the question of whether behavioural factors are a substantive cause of ill-health. I have already argued in the first chapter that it is legitimate to concentrate on proximal and non-background causes when trying to identify the substantive causes of ill-health. However, even if we accept that this approach is legitimate, we still need to establish that human behaviour is, in fact, a substantive cause of ill-health.

In some cases this is easy to do. In the case of most traumatic injuries the causal role of human behaviour is rather obvious. However, geneticists and epidemiologists have recently discovered that a whole range of (relatively proximal and non-background) factors play a much more important role in the aetiology of many diseases than anyone had previously realised. For example, there is good evidence to suggest that women who inherit the BRCA1 and BRCA2 genes are much more likely to develop breast cancer than women who do not (Gage et al 2012). There is also growing evidence to suggest that psycho-social factors like socio-economic status and educational achievement play a direct causal role in the aetiology of many diseases (Wilkinson 1996; Marmot 2004).

My response to these claims is not to dispute them. Indeed, I agree with Golan (2010) that the development of most diseases “*is caused by interactions among genetic and environmental risk factors, including those of lifestyle*” and that the “*patient’s behaviour in the relevant cases may thus be only part of the cause of his or her condition*”. However, even if we take these other factors into account there remains plenty of scope for claiming that human behaviour plays a major causal role in the aetiology of disease. Indeed, even the most powerful advocates of the “*social*

*determinants of health*” approach to disease causation concede that human behaviour is still an important cause of ill-health and may account for more than 30% of all ill-health (Wilkinson and Pickett 2009). Moreover, in some cases, there can be no doubt at all that human behaviour is the key cause of ill-health.<sup>45</sup>

## **4.2 The role of human behaviour in the aetiology of disease**

The role of smoking, sugar, saturated fat, salt, sedentary lifestyles, sporting injuries, unsafe sexual practices, lack of dietary fibre, excessive UV light exposure, unsafe tattooing, alcohol, cocaine, heroin, cannabis, pregnancy, occupational hazards and a whole host of other factors in the development of diseases has been increasingly well documented over the last half century. Such is the scale of behavioural involvement in the causation of ill-health that Callahan (1986) has argued that “*nothing is more evident in the statistics of public health than the role played by individual health behaviour in contributing to accidents, illness and disease*”.

The most recent Public Health White Paper (Department of Health 2010) also states unequivocally that a significant amount of illness and premature death could be avoided if people improved their lifestyles and it suggests that “*a substantial proportion of cancers – and over 30% of deaths from circulatory disease – could be avoided, mainly through a combination of stopping smoking, improved diet and increasing physical activity*”. Furthermore, a recent study indicates that if people changed their lifestyles by adopting four simple health-behaviour goals they would

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<sup>45</sup> Unprotected sexual intercourse, for example, is clearly a substantial cause of sexually transmitted diseases.

cut their risk of developing diabetes, myocardial infarction, stroke and cancer by a staggering 80% (Ford et al 2009).<sup>46</sup>

These figures give us some indication of scale of the involvement of human behaviour in the aetiology of ill-health as well as some indication about how much modification of risk is possible through behavioural intervention. However, it is important to explore in more detail which behaviours are most responsible for contributing to the global burden of disease before moving onto a discussion about moral and consequential responsibility and so I will now discuss some of the more important causes of ill-health beginning with the scourge of the 20<sup>th</sup> century: tobacco.

#### **4.2.1 Smoking**

Smoking is probably the most studied behavioural causes of human ill-health. For many centuries' people have worried that smoking was dangerous. King James I of England (1604) argued in his treatise, *A Counterblaste to Tobacco*, that "*smoking is a custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black, stinking fume thereof nearest resembling the horrible Stygian smoke of the pit that is bottomless*". He even placed a heavy levy on tobacco in an attempt to stop people from smoking (Smokers News 2011). However, it was not until the 1950s that proper scientific evidence began to emerge that smoking caused lung cancer and it took another two or three decades for most scientists to agree that smoking was the primary cause of most forms of lung cancer (Doll et al. 1950; Doll et al. 1994).

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<sup>46</sup> The four goals were: regular exercise, healthy diet, avoidance of smoking and avoidance of obesity.



Would that smoking only caused lung cancer. Unfortunately, we now have good reason to believe that this is not the case because there is considerable evidence to suggest that smoking plays a key causal role in the aetiology of many of the most prevalent and deadly diseases known to humankind, including ischemic heart disease, cerebrovascular disease and Chronic Obstructive Pulmonary Disease (Gorden and Kannel 1972; Anderson et al 1991; Kawachi et al 1993; Jamrozik et al 1994; Ockene and Houston 1997; Forey et al 2011; Kurth et al 2003; Shavell et al 2008).

Smoking is also now regarded as a key cause of a number of different non-lung cancers. For example, Secretan et al. (2009) claim that there is sufficient evidence to claim that smoking plays a major causal role in the aetiology of 14 different types of non-lung cancers including cancer of the stomach, pharynx, pancreas, ovaries, oesophagus, nose, mouth, liver, larynx, kidney, colon, rectum, bone marrow and bladder.<sup>47</sup> There is also some evidence to suggest that smoking plays a causal role in the aetiology of diseases like macular degeneration and some forms of inflammatory bowel disease (Calkins 1989; Vingerling et al 1996).

In terms of its overall effect on the global burden of disease smoking is thought to be responsible for about 25% all cancer deaths worldwide (Secretan et al 2009). This means that smoking is probably the single biggest cause of cancer in the world (Doll and Peto 2003; Sasco et al 2004). The primary reason for this is because lung cancer is one of the most common causes of cancer deaths in the world and 90% of all

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<sup>47</sup> Admittedly, smoking is a much more potent cause of some of these cancers than others. For example, it is believed that the risk of dying from laryngeal cancer is about 20-30 times higher for smokers than non-smokers whereas smoking “only” doubles the risk of dying from kidney cancer (Johnson 2001; Cancer Research UK 2010). However, the evidence for the causal role of smoking in all of these diseases is strong.

primary lung cancer cases are caused by smoking (Doll et al. 2004; Ozlu T and Bulbul Y 2005; Peto et al 2005; Vollset et al 2006).<sup>48</sup> Smoking is also thought to be responsible for about 90% of cases of Chronic Obstructive Pulmonary Disease and about 30% of coronary heart disease deaths (Centres for Disease Control 1990; Young et al 2009).<sup>49</sup>

Smoking is now considered to be the primary preventable cause of illness and premature death in the UK (Department for Health 2010) and the Center for Disease Control and Prevention (1989) in America has called smoking “*the most devastating cause of disease and premature death this country has even seen*”. The World Health Organization (2012a), meanwhile, estimates that 100 million deaths were caused by tobacco in the 20<sup>th</sup> century and that tobacco will kill over 1 billion people in the 21<sup>st</sup> century.<sup>50</sup>

#### **4.2.2 Alcohol**

Alcohol ranks as a close second to smoking both in terms of its known association with disease and its overall impact on health. Alcohol primarily affects the liver and we now have overwhelming evidence that alcohol is causally responsible for a significant number of liver diseases including hepatitis, cirrhosis and hepatocarcinoma

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<sup>48</sup> The lifetime risk of developing lung cancer amongst smokers is thought to be about 17% for men and 11% for women (Villeneuve and Mao 1994).

<sup>49</sup> A number of studies also suggest that people who smoke are two or three times as likely to die from cerebrovascular accidents than people who do not smoke (Shinton et al. 1989; Gill et al 1989; Gorelick et al 1989; Feigin et al 1998).

<sup>50</sup> This implies that more smoking killed more people in the 20<sup>th</sup> century than first and second world wars combined.

(Grant et al 1988; Corroa et al. 1993; Savolainen et al 1993; Becker et al 1996; Bellantani et al 1997; Kamper-Jorgensen et al 2004; Shen et al. 2008; O'Shea et al 2010).

There is also substantial and growing evidence that alcohol is a leading cause of a range of non-liver diseases including: obesity, pancreatitis, cardiomyopathy and hypertension (MacMahon 1987; Criddle et al 1994; Klatsky 2000; Piano 2002; Wannamethee et al 2003; Stranges et al 2004; Djousse and Gaziano 2008; Apte et al 2009; Yadav et al 2009; National Obesity Observatory 2012). A number of non-liver cancers, including cancers of the mouth, pharynx, oesophagus, breast and bowel are also believed to be caused by an excessive consumption of alcohol (World Health Organization 1988; Klygis and Barch 1992; Longnecker 1992).<sup>51</sup> Furthermore, alcohol is a major cause of accidents and, to make matters worse, the consumption of alcohol tends to increase the severity of injuries when accidents do occur (Fuller 1995).

In terms of the impact that alcohol has on ill-health we now have good reason to believe that alcohol is one of the leading causes of early death and disability.<sup>52</sup> In the UK an estimated 33,000 people are believed to die from alcohol related diseases every year (Academy of Medical Sciences 2004). The increased prevalence of regular and heavy drinking has also led to a rapid rise in liver diseases and it is now estimated that liver conditions are the fifth biggest cause of death in England (Department of Health

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<sup>51</sup> For example, one major study suggests that 75% of oesophageal cancers are attributable to alcohol (Stinson and DeBaakey 1992).

<sup>52</sup> In Russia, one of the worst affected countries, alcohol is responsible for causing over 50% of all deaths of working age people and is primarily responsible for the fact that the life expectancy of a Russian male is only 60 years of age (Zaridze et al 2009)

2010). Alcohol is also implicated in about 35-63% of deaths from falls, 12-61% deaths from drowning, 12-61% of deaths from burns injuries and around 25% of deaths from road traffic accidents in the European Union (Institute of Alcohol Studies 2010; European Commission 2011).<sup>53</sup> The World Health Organization (2011) claims that alcohol is responsible for a greater burden of disease than all other risk factors other than smoking and hypertension and Rehm et al (2009) argue that 3.8% of all deaths in the world can be attributed to alcohol.<sup>54</sup>

#### **4.2.3 Illicit recreational drugs**

It is difficult to obtain reliable data on the consumption of recreational drugs – other than tobacco and alcohol – because they are illegal in most countries. However, the British Crime Survey (Home Office 2006) and the National Institute on Drug Abuse (2011) suggest that the most widely consumed drugs in the UK and the USA at the present time are barbiturates, benzodiazepines, cocaine, LSD, psychedelic mushrooms, solvents, cannabis, amphetamines (including ecstasy) and opiates.

The UK Office of National Statistics (2010) reports that about 10% of the population regularly admit to using illegal drugs at least once in the past year and the United Nations (2010) estimates that 185 million people worldwide regularly use illegal drugs. Each of these drugs has its own set of side-effects and many of them are

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<sup>53</sup> 35% of all emergency admissions to hospital in the UK are also directly or indirectly related to alcohol and 7% of all admissions to hospital in the UK are for alcohol-related disorders (Institute of Alcohol Studies 2009).

<sup>54</sup> Rothman (1980) also argues that alcohol is responsible for about 2-4% of all cancer deaths.

associated with a range of different diseases.<sup>55</sup> Some can also lead to physical and psychological addictions.

The sheer number of different recreational drugs used means that I cannot hope to discuss the impact that each and every one of these drugs has on human health.<sup>56</sup>

However, the UK Office of National Statistics (2007) estimates that thousands of deaths are caused by the use of recreational drugs every year in England and Wales and the World Health Organization (2012b) calculates that around 0.4% of all deaths worldwide are caused by illicit drug use.

#### **4.2.4 Food**

Of all the many factors that influence our health it is likely that it is the food that we consume that causes us the most problems and gives us the greatest scope for control over our own health. Indeed, a former Surgeon General of the USA once claimed that 75% all Americans were dying from diseases that were directly related to their eating habits (United States Public Health Service 1988). In this section I will briefly list some of the foodstuffs that are considered most dangerous to our health and give some indication of the scale of the problems that they cause.

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<sup>55</sup> Chronic cocaine use, for example, can destroy the nasal septum, cause permanent renal damage and doubles the risk of cerebrovascular accidents (Vilensky 1982; Fokko 2000; Westover 2007).

<sup>56</sup> Some drug users develop infectious diseases like HIV and Hepatitis B because they share their needles (Aceijas et al. 2004; Palamateer et al. 2010).

#### **4.2.4.1 Sugar: pure, white and deadly?**

There is overwhelming evidence that consuming too much sugar plays a key role in the development of dental caries (Touger-Decker and Loveren 2003).<sup>57</sup> This is primarily because some of the simple sugars that we eat remain in our mouths long after we have finished eating and many of them are fermented by micro-organisms to create acids which demineralise the enamel of our teeth (Hardie 1982; Holloway 1983).

There is also growing evidence that excessive sugar consumption plays a causal role in the aetiology of type 2 diabetes – although this association is a matter of some dispute.<sup>58</sup> On the one hand, there is a strong correlation between the rapid increase in the consumption of sugar that occurred over the last century and the rapid increase in the rates of type 2 diabetes. For example, a recent study by the U.S. Department of Agriculture (CSPI 2000) notes that the average American was consuming 30% more sugar in 1999 than they did in 1983. Moreover, many studies suggest that consuming simple sugars increases blood sugar level far more than the consumption of complex carbohydrates (Crapo et al. 1976). Reducing the consumption of simple sugars also helps to manage and control blood glucose levels amongst patients who suffer from the condition (Thomas and Elliott 2009; Garg 1994).

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<sup>57</sup> Dental caries are also caused by a failure to maintain good oral hygiene and this failure can be regarded as a “behavioural” cause of disease too.

<sup>58</sup> Type 1 diabetes is not caused by sugar. Its aetiology is unknown and so there is no reason to think that this form of diabetes is linked to human behaviour.

On the other hand, there is some countervailing evidence which indicates that there may be no direct link between the consumption of sugar and the incidence of diabetes (Janket et al. 2003). A number of researchers claim that it is obesity, rather than the consumption of sugar, that is the primary cause type 2 diabetes (Zimmet et al. 2001; Maggio & Pi-Sunyer 2003). This latter theory is reinforced by the fact that 80% of people with type 2 diabetes are overweight or obese at the time of diagnosis (Diabetes UK 2009).

Nevertheless, even if obesity, rather than sugar consumption, is the primary proximal cause of type 2 diabetes, there is little doubt that one of the key causes of obesity is the over-consumption of energy dense foods and drinks – many of which contain substantial amounts of refined and simple sugars. Hence, even if we discover that the over-consumption of sugar does not lead directly to type 2 diabetes, it is likely that we will still be able to claim that this behaviour is an important, in-direct, cause of this common disease.

In terms of impact on global health dental caries and diabetes have serious ramifications. Dental caries affect around 60-90% of all people at some stage in their lives and this disease may well be the most common chronic disease of all amongst children and young adults (Marthaler et al. 1996; World Health Organisation 2012c).<sup>59</sup>

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<sup>59</sup> Many argue that the reason for why children and young adults are affected more than older adults is because young people consume large amounts of confectionary and carbonated drinks and these products contain a great deal of acid and sugar (Cheng et al 2009; Sayegh et al 2002; Harding et al 2003).

Type 2 diabetes is a complex disease to manage in its own right and it can also cause a plethora of other diseases including macrovascular diseases like coronary artery diseases, cerebrovascular and peripheral vascular diseases, and microvascular diseases like nephropathy, neuropathy and retinopathy (World Diabetes Foundation 2012). Given that 6.4% of all the worlds' 7 billion citizens – including 8.3% of all Americans and 4.5% of all British people – are now thought to be diabetic this is a very serious issue indeed (American Diabetes Association 2011; Diabetes UK 2011; World Diabetes Foundation 2012). In fact, type 2 diabetes is one of the most common causes of chronic ill-health in the developed world and since the prevalence of this condition is increasing rapidly its contribution to the global burden of disease will only increase over the next few decades.<sup>60</sup>

#### **4.2.4.2 Salt: equally pure, equally white, and equally deadly?**

The relationship between salt and disease is complex and controversial. Many studies have now shown that there is a strong correlation between the consumption of high levels of salt and primary hypertension (Poulter 1990; Elliott and Stamler 2002; He and Whelton 2002; MacGregor and Wardener 2002). There is also much evidence to suggest that reducing salt intake leads to a reduction in hypertension (Appel et al. 1997; Sacks et al. 2001; He and MacGregor. 2005; Strazzullo et al. 2009). On the other hand, some studies have indicated that the correlation between salt and hypertension may not be causal and that a reduction in dietary salt has little effect on mortality (Alderman 2002; Freeman and Petitti 2002; Dumler 2009).

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<sup>60</sup> Diabetes UK (2010) estimates that 430 million people around the world will be living with diabetes by 2030.



Nonetheless, the Scientific Advisory Committee on Nutrition (2003) states that the evidence in favour of the claim that excessive salt consumption causes hypertension is sufficiently robust for policy makers to take heed of this information and for politicians to advise their citizens to reduce their salt intake as a precautionary measure. Many governments around the developed world agree have subsequently put in place policies which are geared to reduce the amount of salt that people eat (Perry 2003). The Food Standard Agency (2004) in the UK, for example, launched a campaign a few years ago (“*Salt – Watch It*”) which was designed to warn people about the dangers of excessive salt consumption and to encourage people reduce their daily consumption of salt.<sup>61</sup>

The association between salt and hypertension matters because primary hypertension is a very common disease – Bajektal *et al* (2003) estimate that the prevalence of hypertension is about 41% in men and 35% in women in England – and there is much evidence to suggest that hypertension is one of the major causes of coronary artery disease, cerebrovascular diseases and hypertensive retinopathy (MacMahon et al 1990; Wong and Mitchell 2004; Donnan et al 2008).<sup>62</sup>

Trying to calculate the exact contribution of hypertension to the global burden of disease is extremely difficult because this disease causes a wide array of different conditions and many of these are caused by multiple factors. Nonetheless, we have

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<sup>61</sup> The campaign recommended that adults should reduce their consumption from the current 11g for men and 8g for women to a maximum of 6g for men and women (Food Standard Agency 2004).

<sup>62</sup> On the plus side it has been demonstrated that a population wide reduction in salt intake could reduce the incidence of these diseases significantly and that people who suffer from high blood pressure who significantly reduce the amount of salt in their diet can decrease their chances of developing cardiovascular disease by over 25% (Stazullo et al 2009).

good reason to believe that hypertension plays a key causal role in the development of three of the ten most common causes of death in the developed world and we have good reason to believe that hypertensive heart disease accounts for 2.3% of all deaths in high income countries (World Health Organization 2008).<sup>63</sup> As such, we have sufficient reason to conclude that hypertension is one of the most important causes of ill-health worldwide.

#### **4.2.4.3 Saturated fat**

The claim that excessive consumption of saturated fat is one of the main causes of cardiovascular diseases is, like the claim about the causal association between salt and hypertension, rather controversial. There is an abundance of evidence to suggest that the consumption of excessive amounts of saturated fat increases the probability of developing cardiovascular diseases and that replacing saturated fat with other forms of fat is effective in lowering the risk of coronary heart disease and strokes (Clark et al. 1997; Hu et al. 1997; Hu et al 2001; Jakobsen 2009; Mozaffarian 2010).<sup>64</sup>

However, there is also some countervailing evidence to suggest that excess saturated fats is a confounding factor and is not responsible for causing vascular disease (Mente et al. 2009; Siri-Tarino et al. 2010).

The World Health Organization and the Food and Agricultural Organization (2003) have recently reviewed the evidence and have come to the conclusion that there is sufficient evidence to claim that the “*intake of saturated fatty acids is directly related*

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<sup>63</sup> The three are: cardiovascular, cerebrovascular disease and hypertensive heart disease.

<sup>64</sup> The most recent systematic review concludes that reducing saturated fat in the diet reduces the risk of having a cardiovascular event by at least 14% (Hooper et al. 2011).

*to cardiovascular risk*". Moreover, many developed world governments have concluded that the weight of evidence is sufficient to warrant a health policy response. For example, the UK and US governments now advise British and American citizens to reduce the consumption of foods which contain high levels of saturated fat (Food Standards Agency UK 2006; U.S. Department of Agriculture and U.S. Department of Health and Human Services 2010). Denmark, as I noted in earlier, has even placed a "fat tax" on products containing more than 2.3% of saturated fat in an effort to reduce consumption (BBC News 2011).

As with salt and sugar, quantifying the degree of harm that an excessive consumption of saturated fat actually causes is very difficult. This is because the diseases that saturated fats cause are also caused by a range of other dietary (and non-dietary) factors. However, cardiovascular disease is the most common cause of death worldwide and if saturated fats really are responsible for causing around 14% of deaths from this disease we have good grounds for claiming that the excessive consumption of saturated fat is a serious cause of ill-health (World Health Organization 2008).

#### **4.2.4.4 Meat, fibre, fruit and vegetables**

A diet low in fruit and vegetables is thought to cause a number of problems. In the first instance, such a diet is likely to be low in fibre and there is much evidence to suggest that diets which are low in fibre contribute to bowel, rectal and anal diseases like bowel cancer, diverticulosis and haemorrhoids (Thun et al 1992; Aldoori 1997; Cummins 2001; Petruzzello 2006). There is also little doubt that unbalanced diets

which are low in fruits and vegetables can lead to whole host of vitamin and mineral “deficiency diseases” such as scurvy (Ellis et al. 1984).<sup>65</sup> Some researchers even claim that a diet high in fibre, fruit and vegetables reduces the risks of coronary heart disease, cerebrovascular disease, hypertension, diabetes, obesity and breast cancer – though these claims are disputed (Liu et al 1990; Block et al 1992; Montonen 2003; Steffen et al 2003; Lairon 2005; Whelton 2005; Anderson et al 2009).

A number of other studies have linked the consumption of red meat – especially in its processed form – with bowel cancer (Walter et al 1990; Bingham 1999; Giovannucci et al 1994). One study, in particular, found that people who eat two portions a day of such meat increase their risk of bowel cancer by 35% by comparison with people who eat one portion a week (Boffetta et al 2010). These findings are still relatively new and controversial, but the weight of evidence is growing and the UK government already advises British citizens to reduce the amount of processed red meat that they eat (Department of Health 2011b).

Calculating the degree of harm caused by diets which are low in fruit, vegetables and fibre and high in red meat is not an easy task. We know that diseases caused by mineral and vitamin deficiencies are accountable for a significant burden of disease in the developing world, but these diseases are now relatively rare in the developed world because processed food is increasingly fortified with vitamins and minerals.

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<sup>65</sup> Rather worryingly, the majority of adults living in the UK do not consume even the minimum amount of recommended fruit and vegetables every day (Department of Health 2010). For example, the Food Standards Agency (2009) suggests that only 30% of adults eat the recommended 5 portions of fruit and vegetables a day and 10% fail to eat even one portion of fruit or vegetables on most days of the week.

However, bowel cancer is the second most common cancer in the UK (Cancer Research 2010) and many of the other diseases which seem to be partially caused by diets low in fruit, vegetables and fibre are extremely common too. Hence, we have reason to believe that a diet low in fruit and vegetables – and a diet high in certain forms of meat – causes a significant amount of the global burden of disease.

#### **4.2.4.5 Calorie consumption, calorie use and the problem of obesity**

An individual's weight or Body Mass Index (BMI) generally depends on two main factors: the number of calories consumed and the number of calories used in various metabolic processes. If an individual eats more calories than his or her body "uses" most of the remainder will be stored and if this continues over the medium to long term the individual will gain weight and might become overweight or obese (Langlois et al. 2009).

These casual claims are, more or less, undisputable and there is a significant amount of evidence to suggest that the reason why rates of obesity have soared over the last half a century is because people now consume more calories and exercise less than they did in the past (Lin et al 1999; Salmon and Timperio 2007; World Health Organization 2012d). The evidence for these causal claims is also heavily supported by the fact that the key treatment for obesity and overweight is to eat fewer calories and exercise more regularly (Wadden et al 2005; Lau et al. 2006).

The exact reason why people have started to eat more calories and exercise less often is not entirely clear. One reason why we consume more calories than we did in the

past is probably because there is now a greater availability of inexpensive, high-energy, foods. It is also likely that we expend less energy than we did in previous decades because most people are now employed in less physically undemanding work that they used to be. We also now have access to a whole raft of labour saving technologies (e.g. mechanized transport, television, computers and the internet) which means that there are strong incentives to avoid regular exercise in our daily life (Tucker and Bagwell 1991; Gortmaker 1996; Hu et al 2003; Jakes et al 2003; Dunstan et al 2005; Mota et al 2006; Vandelandotte et al 2009).

Whatever the reason for these behavioural changes, the impact on human health has been devastating. This is because obesity causes a great deal of disability in its own right and it is also one of the primary causes of hypertension, hypercholesterolemia, coronary artery disease, cerebrovascular disease, type 2 diabetes, gallstones, osteoarthritis, cancer and a number of other common diseases (Bray 1985; Klein et al. 2002; Haslam and James 2005).

The burden created by overweight and obesity is also growing rapidly not only because an ever increasing number of people are overweight or obese but because the degree of obesity seems to be getting worse. In England, the prevalence of obesity has more than doubled between 1985 and 2010 (National Obesity Observatory 2010). This means that around 2 out of 3 adults are currently overweight or obese and if the trend continues around 60% of Britons will be obese by 2050 (Department of Health 2010). The American figures are even more alarming: 13% were obese in 1962, 31% were obese in 2000 and around 35% were obese in 2009 (Centers for Disease Control and Prevention 2012a). Given the amount of harm that obesity causes this almost

certainly means that obesity will soon become the single biggest cause of ill-health in most developed world countries. Indeed, it has been suggested that obesity may already cause more deaths in the USA than smoking (Centers for Disease Control and Prevention 2004).

#### **4.2.5 Sex, sexually transmitted diseases and pregnancy**

Human beings have long understood that unprotected sexual intercourse increases the risk of developing certain diseases. We have also known for well over a century that the reason why this happens is because certain micro-organisms can be transmitted from person to person during unprotected sexual intercourse. In fact, we now know that there are over 30 different kinds of infectious organisms that can be transmitted this way. These range from relatively harmless infections such as *Trichomonas*, *Candida* and Herpes, to potentially lethal infections such as Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (World Health Organization 2009a).<sup>66</sup> There is also overwhelming evidence to suggest that unprotected sexual intercourse increases the probability of developing cervical cancer because certain forms of a virus which can be transmitted sexually (i.e. the Human Papilloma Virus) causes around 90% of all cervical cancer cases (Muñoz et al. 2004; Schiffman et al. 2007).

The prevalence of sexually transmitted infections is significant and increasing worldwide. The World Health Organization (2001) calculates that there are in the order of 340 million new cases of curable sexually transmitted infections every year and the figures for “incurable” sexually transmitted infections runs into the tens of

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<sup>66</sup> HIV and some other infectious diseases can also be transmitted vertically (i.e. from mother to foetus) and via blood products (e.g. via blood transfusions and needle sharing).

millions. For example, around 34 million people are now infected with HIV worldwide (World Health Organization 2010).<sup>67</sup>

Mercifully, the prevalence of serious sexually transmitted infections like HIV are relatively low in the developed world, but the prevalence of less serious sexually transmitted infectious diseases are relatively high and increasing rapidly. For example, the incidence of Chlamydia in the UK doubled between 1999 and 2009 and an estimated 75% of the reproductive-age population have now been infected with Human Papilloma Virus (Centers for Disease Control and Prevention 2000; Avert 2011).

Sexually transmitted infections are not the only consequence of unprotected sexual intercourse – at least among heterosexuals of a reproductive age. The other main consequence is pregnancy. There has recently been much interesting debate about the “over-medicalisation” of pregnancy. However, pregnancy remains a relatively dangerous process – especially in the developing world where around 350,000 women die each year as a result of the complications of pregnancy or childbirth (WHO 2009b). Moreover, though maternal mortality rates are very low in the developed world, pregnancy and childbirth still causes a great deal of ill-health and injury. For example, pregnancy can cause gestational forms of hypertension and diabetes and childbirth can cause lacerations, infection and haemorrhage. Thus, unprotected sexual intercourse can cause a significant amount of ill-health and, at least in some countries, it is a major cause of preventable disease.

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<sup>67</sup> It should be noted that HIV and Hepatitis B can be transmitted through blood transfusions and by sharing needles when injecting drugs or medications.



#### **4.2.6 Ultra violet light: suntans and sunbeds**

Over four decades ago it was claimed that excessive exposure to Ultra Violet (UV) light could cause skin cancer. This claim was initially disputed, but there is now plenty of evidence which suggests that exposure to UV causes a number of different cancers including malignant melanomas, basal cell carcinomas and squamous cell carcinomas (Urbach 1989; Brash et al. 1991). The primary source of UV radiation is the sun, but tanning machines also make use of UV light and are another key source of this form of radiation (Centres for Disease Control and Prevention 2012).

The rates of skin cancer in Australia, Europe and elsewhere have increased rapidly over the last 50 years. For example, the incidence of melanoma in the UK has increased by a factor of 4 since the early 1970s (Cancer Research 2012). There is no real consensus as to why this has happened, but three theories predominate. Firstly, the ozone layer – which protects the earth from UV light – has been depleted (Diepgen and Maler 2002). Secondly, people in Europe and North America increasingly spend more of their annual leave in tropical and sub-tropical countries where they are exposed to high levels of sun radiation (Bentham and Aase 1996). Thirdly, the social value of having “tanned” skin has led to people increasing their exposure to both sunlight and artificial light in tanning salons (Cancer Research 2012).

Whatever the reason for this behaviour change, the effects have been profound. In the UK around 100,000 cases of skin cancer are now diagnosed each year and around 10% of these cases are melanomas – the especially dangerous form of skin cancer

(Cancer Research 2012).<sup>68</sup> The situation in Australia is even worse and it has been estimated that Australians now have the highest rates of skin cancer in the world (Australian Institute of Health and Welfare and Australasian Association of Cancer Registries 2004).<sup>69</sup> The prevalence of this disease is also very high and increasing rapidly in many European and North American countries and so we have good reason to claim that skin cancer contributes greatly to the burden of disease in some countries.

#### **4.2.7 Exercise and sports**

The claims that regular exercise improves our health and that a failure to exercise regularly tends to be deleterious for our health dates back to the days of Hippocrates. But this long established belief is now firmly based on scientific evidence. Many studies have shown that regular aerobic exercise reduces blood pressure, reduces blood glucose levels and reduces dangerous forms of blood cholesterol levels (Duncan et al. 1985; Marcia et al. 1998; Kelley et al 2001; Borer et al. 2009). Other studies have demonstrated that a failure to exercise regularly is an independent risk factor for cardiovascular disease and type 2 diabetes (Castelli 1984; Hu et al. 2001). Exercise is also one of the key determinants of weight and obesity (Slentz et al. 2009).

Quantifying the impact of a failure to exercise regularly on ill-health is difficult. However, a recent study argues that physical inactivity causes 7% of all cases of type

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<sup>68</sup> About 25% of patients diagnosed with this condition eventually die from the disease (Ibid).

<sup>69</sup> Australians are four times as likely to develop a form of skin cancer as they are to develop any other cancer (Australian Institute of Health and Welfare and Australasian Association of Cancer Registries 2008).

2 diabetes, 6% of all cases of coronary heart disease, 10% of all cases of breast cancer and 10% all of all cases of colon cancer (Lee et al. 2012). The same report concludes that inactivity causes about 9% of premature mortality which equates to 5.3 million deaths in 2008 (Ibid, p220). These figures are likely to get worse with time because the prevalence of inactivity seems to be increasing both in children and in adults (Department of Health 2011c).

We must bear in mind, however, that exercise is a double edged sword. Whether we run or swim or cycle we expose ourselves to physical injury in the process. Moreover, engaging in any form of exercise is dangerous in some sense (Harris 1995; Holm 2006; Golan 2010). Sprained ankles, ruptured knee ligaments and broken fingers are just some of the more mundane consequences of leading an active life. In rare circumstances exercise can even cause sudden death and a small number of people also die every year whilst playing contact sports such rugby or engaging in extreme sports such as scuba diving (Tucker and Douglas 2007).

On the balance of probabilities, however, exercising regularly (especially where the exercise does not involve some kind of extreme sport) is far more likely to improve health than damage it and there is increasing reason to believe that living a sedentary life significantly increases the risks of ill-health and premature death.

#### **4.2.8 Occupational hazards**

It has long been known that occupational hazards can cause serious injuries and various form of ill-health. Some jobs are so risky that employer's offer a "risk bonus"

as a form of compensation for employees who are willing to do these jobs. Many of the most dangerous jobs involve manual labour, but jobs which do not involve manual labour can also pose risks to people's health. Marmot (2004), for example, has demonstrated that civil servants working in Whitehall were at higher risk of developing a whole range of common diseases if they were working in the middle or lower echelons of the organisational hierarchy.

The amount of illness and injuries caused by occupational hazards are not inconsequential either. The Bureau of Labour Statistics (2010) claims that around 5000 people die every year in the United States as a result of accidents at work and the Health and Safety Executive (2012) in UK states that 115,000 injuries were reported in UK in 2010-2011.<sup>70</sup> One study even suggests that “*baby boomers*” in the USA lose about 500 million days of productivity annually because of “*sports related injuries*” (Glantz 2007). These are significant numbers and they suggest that people's occupation plays a key role in determining people's levels of health and ill-health.<sup>71</sup>

#### **4.2.9 “Everyday” behaviour, “everyday” risks**

Sometimes people knowingly take risks with their health. This is true when people sky dive, ski or scuba dive. But people also take risks without really thinking about it when they engage in what I will call “everyday activities”. These activities are far too

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<sup>70</sup> The Health and Safety Executive (2012) claims that 1.2 million working people were suffering from a work-related illness during this time too

<sup>71</sup> Unemployment can be very bad for people's health too, but this does not detract from the fact that employment can be dangerous.

numerous to enumerate, but they include such mundane things as driving to work, preparing food with sharp instruments and crossing busy streets.

Putting actual figures on the risks posed by everyday activities is virtually impossible. In the case of road traffic accidents data is collected and we know that around 2000 people die – and a further 23,000 people are seriously injured – on UK roads each year (Department for Transport 2012). The World Health Organization (2002) also estimates that around 1.26 million deaths occur worldwide as a result of road traffic accidents.

However, data about other kinds of risky behaviour is not usually collected and thus it is exceptionally hard to know how many people, for example, lacerate their skin with a kitchen knife whilst preparing food. However, even if good data is lacking it is reasonable to believe that these everyday risks do contribute a fair amount to the global burden of ill-health and that we should not discount everyday risks when we consider the causal role of human behaviour in the aetiology of ill-health.

#### **4.2.10 Preventative health care**

The decision whether or not to access high quality preventative health care – at least in countries where such care is free and readily accessible – is another key “behavioural” determinant of health. The modern medical profession is primarily occupied with treating diseases after they have occurred, but a number of preventative health care schemes are in operation and the concept of preventative medicine is finally beginning to gain the attention of those who run and organise health services

around the developed world. This means that patients increasingly have the opportunity to take preventative measures to avoid becoming ill – especially in the form of vaccinations and screening tests.

Of course, most vaccines are given to children and so the decision whether or not to have a vaccine is, in the first instance, the responsibility of parents. However, people who were not vaccinated as children sometimes have the option of being vaccinated as adults. As such, there is scope for arguing that some adults are partially causally responsible for developing some infectious diseases that they could have been vaccinated against (Veatch 1980).

Screening tests also offer people the opportunity for people to use medical technology in a preventative fashion. The primary goal of screening is to test people who are at risk of developing a disease either in order to detect a “pre-disease state” or to detect a disease at an early stage in its development. Doing so can either prevent a disease from occurring or help doctors to either “cure” a disease at an early stage or prevent long term complications. As with vaccines, people who choose not to engage with regular screening programmes and who later develop a disease that might have been detected by the screening test may be deemed partially causally responsible for their ill-health.

Given the huge role that health care can play in preventing diseases we can safely claim that a failure to make use of preventative health care – where it is offered – is a major cause of ill-health. Indeed, it is likely that tens of thousands of people die

prematurely each year because they decided not to make use of the screening and vaccination programmes made available to them.

#### **4.2.11 Post diagnosis behaviour**

Once a patient has been diagnosed with a disease the progression of that disease often depends on how the patient decides to respond. In some cases there is little that a patient can do to change the natural progression of a disease.<sup>72</sup> In other cases, however, the behavioural response of patients post-diagnosis plays a critical role in determining the success or otherwise of treatment and management. Indeed, in some cases patients may even be able to cure the disease that afflicts them or at least ensure that the disease goes into remission. For example, patients suffering from type 2 diabetes can usually bring their disease under control if they monitor their disease closely, take medication regularly and modify their lifestyles (Rispin et al. 2009). Patients who are obese can also return to a normal weight if they exercise more and consume fewer calories.

People's behaviour post diagnosis may also impact on disease development even when the disease itself is not caused by human behaviour. For example, the progression of Cystic Fibrosis is very much affected by the willingness of those affected to receive regular physiotherapy, to take regular medication and to attend regular appointments (Jaffe and Bush 2001). The same can be said of type 1 diabetes and many other conditions which are not caused by human behaviour. In the case of Cystic Fibrosis much of the responsibility for good management falls on the parents

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<sup>72</sup> Smokers who have developed end stage lung cancers cannot prevent the progression of their diseases by giving up cigarettes

rather than the afflicted children. However, when these children grow up the decision to keep adhering to treatment will be made by them and the same is true of other conditions that affect adults who are not responsible for their illnesses and injuries. Of course, in these cases causal responsibility for health outcomes will always remain marginal because the primary cause is not linked to human behaviour. However, we should not forget that many diseases and injuries can be well managed and even cured if people take appropriate actions even when the disease and injuries are not themselves caused by the behaviour of those afflicted.

### **4.3. Conclusion**

I mentioned in the first chapter – and again at the beginning of this chapter – that I would not attempt to provide an exhaustive list of all the causal links between human behaviour and ill-health in this thesis. Instead, I said that I would concentrate on the behaviours that are thought to contribute most to the global burden of disease and this is what I have done in this chapter. Whether the people who are causally responsible for their ill-health are also morally responsible for partaking in these behaviours and whether they ought to bear costs are entirely separate questions. But, at this point in my analysis, I hope that I have demonstrated that Harris’ (1995) claim that “*any serious list of people who have or share responsibility for their own adverse health state would have to include a high proportion of the entire population*” is true and that a significant proportion of the global burden of disease is related to our life-style choices.



## Chapter 5

### Moral Responsibility for Health

*“The Law acquits me, innocent, as ignorant*

*Of what I did.”*

*– Sophocles*

#### 5.0 Introduction: moral responsibility for health

The philosophical debate about the nature, existence and scope of moral responsibility has been ongoing for millennia. The ancestry of the debate can be traced all the way back to Aristotle’s (1984) discussion of reactive attitudes like praise and blame. The more specific debate about the nature, existence and scope of moral responsibility for health is equally ancient and this debate, as we can see from the following quote, can also be traced back to Aristotle:

*“Though no one blames a man for being born ugly, we censure uncomeliness that is due to neglecting exercise and the care of the person. And so with infirmities and mutilations: though nobody would reproach, rather pity, a person blind from birth, or owing to disease or accident, yet all would blame one who had lost his sight from tippling or debauchery. We see then that bodily defects for which we are ourselves responsible are blamed, whilst those for which we are not responsible are not” (Aristotle 1984).*

In this chapter I will argue that a significant number of the people are, to a large extent, morally responsible for choosing to engage in risky health affecting behaviours. I will rest this claim on the ground that the mental capacity, freedom and epistemological conditions of moral responsibility obtain in the case of most risky health affecting behaviours. I will also, however, argue that people's degree of moral responsibility varies quite considerably and that, in some cases, people are either not morally responsible at all or only marginally so.

I will divide this chapter into three sections. The first section will deal with the mental capacity condition, the second will deal with the freedom condition and the third will deal with the epistemological condition. In each section I will briefly discuss the nature and relevance of the condition in question before going on to explore the extent to which each condition actually obtains in the real world.

### **5.1 The mental capacity condition: introduction**

It has long been argued that mental capacity is an important and necessary condition of moral responsibility (Glannon 2002). However, mental capacity is a complex phenomenon. One element of this complexity stems from the fact that the concept of mental capacity does not refer to one specific mental ability or capability and that experts cannot agree on which set of capacities is needed for moral responsibility. Another aspect of this complexity derives from the fact that the concept of mental capacity can be described in both a "global" and a "local" sense (Herring 2010). In day to day life we generally speak of people as either having capacity or lacking

capacity, but in medical practice (and at law) capacity is considered to be “task specific” (General Medical Council 2008).

In this chapter, I will suggest that we should think of mental capacity as a set of different capacities rather than as some singular phenomenon. This is because people need a whole range of different mental capacities, including cognitive and conative capacities, in order to be morally responsible for their risky health affecting choices. I will also suggest that we should construe mental capacity as a task specific phenomenon. This is because it makes sense to say that people have the capacity to perform some tasks, but lack the capacity to perform other tasks. Indeed, the capacity to be morally responsible for our risky behaviours is a good case in point because the number of capacities that we need in order to be morally responsible far outweighs the number of capacities we need to perform much simpler tasks.

### **5.1.1 Which mental capacities do we need to be morally responsible for our risky health affecting behaviours?**

The civil law in England and Wales takes a rather basic approach to the question of mental capacity in general. According to the Mental Capacity Act (2005) people are defined as possessing mental capacity – including the capacity to make risky health affecting decisions such as refusing treatment – if four conditions are met. These four conditions are as follows: the individual must be able to understand relevant information, retain this information, deliberate using this information and communicate the decision that they make (Herring 2010). The criminal law in England and Wales sets up different rules for capacity in relation to criminal

responsibility. In particular, there is a requirement that individuals have the capacity to understand the nature of their actions and the capacity to understand the nature of right and wrong if they are to be regarded as criminally responsible for their actions (Wilson 2002).

These civil and criminal rules regarding mental capacity are helpful in that they give us a pointer about the kinds of capacities people need to have in order to be morally responsible for their risky health affecting behaviours. However, a more systematic and thoroughgoing account of capacity is needed in order to ground claims of moral responsibility. In particular, I agree with Glannon (2002) that in order to be morally responsible for their risky health affecting behaviour people need a mix of different conative, cognitive, affective and volitional capacities.

In terms of the conative capacities people cannot be morally responsible unless they have the general capacity to form desires as well as the more specific capacity to form the desire to be healthy. This is because, if they lack these desires, they will lack the capacity to be motivated to take steps to protect their health. One might think that no human being could possibly lack either the general or the specific conative capacity that I have just mentioned. However, people who suffer from severe forms of depression may well lack the capacity to desire their own health and some people sustain such serious head injuries that they are no longer capable of forming any desires at all.

In addition to needing conative capacities, people cannot be morally responsible unless they possess a whole array of cognitive capacities. These include the capacity

to form health orientated intentions, the capacity to understand relevant health information, the capacity to understand the empirical and normative consequences of their risky choices and the capacity to understand the probability that their actions will have certain consequences. Furthermore, they need the cognitive capacity to both perceive reasons for actions – including moral and prudential reasons to take risks and to avoid taking risks – and the capacity to deliberate in a reflexive manner on the basis of these reasons.<sup>73</sup>

People also need the affective capacities to form and possess emotions in a general sense – and the capacity to emotionally identify with the beliefs, values and reasons that form the basis of their risky behaviours – in order to be morally responsible for these behaviours. Possession of these capacities is vitally important for moral responsibility because emotions positively influence people's beliefs and desires and play an important part in practical reasoning. Indeed, people who lack affective capacities have problems making sensible decisions and tend to make defective long term plans (Goldberg 2001).

The capacity to have emotions is, thus, essential because without it the other capacities which are necessary for moral responsibility – such as the conative and

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<sup>73</sup> Not everyone will agree that people need the capacity to perceive moral reasons in order to be morally responsible. Indeed, Aristotle argued that people can be morally responsible even if they lack moral capacities (Glover 1970). However, most contemporary philosophers disagree with Aristotle on this point. For example, Wolff (1998) argues that the *“ability to do the right thing for the right reasons...to choose and act in accordance with the True and the Good”* is fundamental to the notion of moral responsibility. In a similar vein, Fischer and Ravizza (1998) suggest that people must have the ability to respond to moral reasons in order to be morally responsible and Watson (1987) argues that individuals must have the capacity to act on the basis of desires and reasons which are themselves based on an individuals' values and beliefs about what is right and wrong if any form of moral responsibility is ever going to obtain.

cognitive capacities discussed above – will not function effectively (Sousa 1987; Elster 1998; Greenspan 1988).<sup>74</sup>

Finally, people need a number of volitional capacities if they are to be correctly described as possessing the capacity for moral responsibility. These include the capacities to execute their desires, reasons and intentions. These are vital because they enable people to convert their desires, reasons and intentions into actual behaviour (Glannon 2002). To put it another way, people need the capacity to *respond* to reasons, desires and intentions if they are to be regarded as morally responsible for their choices. Furthermore, people need the volitional capacity to respond to reasons in a very specific sense if they are to be morally responsible for their health affecting choices. In particular, people must have the ability to override desires, intentions and reasons to engage in risky health affecting behaviours *if* there are better (i.e. stronger normative and/or stronger prudential) reasons not to engage in these behaviours (Fischer and Ravizza 1998).

It is also worth bearing in mind that all the capacities that I have listed above need to interact with each other if people are to be regarded as morally responsible. For example, if an individual is capable of responding to reasons and feeling emotions, but their reasons and emotions cannot interact with each other it is not unreasonable to claim that such an individual can be morally responsible for his choices. I will not explore the importance of this “meta” capacity in more detail here, but I hope that it is

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<sup>74</sup> It is important to emphasise this point because there is a tendency to believe that emotions cloud judgment and negatively impact on our capacity to reason. However, although this can be the case, emotions can also improve our ability to reason, especially about normative issues, because emotions help us to think about and imagine the impact that our choices will have on others.

reasonably obvious that if people's individual capacities operate entirely separately from each other – as might happen in certain cases of mental ill-health – the individual who experiences this disjointed medley of capacities will lack the overall capacity to be morally responsible for the choices that they make.

### **5.1.2 Do most people have sufficient capacity to be morally responsible for their risky health affecting behaviour?**

The law in England and Wales requires health care professionals to presume that everyone over the age of 16 has sufficient mental capacity to make decisions about their own health affecting behaviours – including their decisions about whether or not to receive life saving treatment (Mental Capacity Act 2005). The law also requires doctors to have strong reasons for actually calling people's capacity into question (Jackson 2009). In other words, the presumption in favour of mental capacity is very strong. It is also the case that there is a default assumption in the criminal law that all adults have sufficient mental capacity to be criminally responsible for their actions. As with mental capacity in civil law, this presumed capacity for criminal responsibility is defeasible, but much evidence is required to prove that people lack the capacity to be criminally responsible and it is fair to say that the presumption in favour of capacity in the criminal law is very strong too (Wilson 2002).<sup>75</sup>

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<sup>75</sup> In most countries adults also have the legal right to purchase cigarettes, alcohol and a range of “risky” food products as well as the legal right to engage in risky health affecting behaviours such as scuba diving, skiing and sky diving without having to prove that they have the mental capacity to be legally responsible for their choices.

One might argue that these strong presumptions in favour of capacity are simply a matter of public policy. It would be extremely onerous to create a legal system which required people's capacity to be constantly assessed and, for this very practical reason, decisions are made to make default assumptions about people's capacity. However, although there is some truth to this claim the law stands as it does because it reflects the common sense intuition that most adults do have sufficient capacity to be responsible for most of their choices in both a legal and a moral sense. Indeed, the reason why the law recognises that most people have the legal capacity to choose whether to attend regular medical appointments, whether to drink alcohol excessively and whether to engage in high risk sports is precisely because we assume that in every day life people have the capacity to be morally responsible for their behaviours (Dietrich 2002).

Even with a strong presumption in favour of capacity, common sense intuition, like the law, does allow that some people lack sufficient capacity to be morally (or legally) responsible for their choices. It is routinely argued that young children and adults suffering from serious brain injury or mental health conditions lack the mental capacity to be morally responsible for the risky health affecting choices (Fischer and Ravizza 1998). A number of commentators have also suggested that a range of different genetic and psycho-social factors can seriously diminish people's capacity to be morally responsible for their risky choices (Buyx 2008). I would add that it might be possible to argue that a significant number of "normal" adults lack the capacity to be morally responsible even if they are not adversely affected by different genetic and psycho-social factors.



I do not deny that young children often lack the capacity to be morally responsible for their health. I also quite agree that adults who suffer from moderate to severe forms of brain damage and moderate to serious forms of mental health problems lack the capacity to be morally responsible for their risky choice. However, I do not wish to be side tracked by these issues in this chapter and so I will simply stipulate at this point that all children (i.e. everyone under the age of 18) and all adults suffering from severe brain injuries or serious mental health conditions lack sufficient mental capacity to be responsible for their risky health affecting choices. Instead, I will take a closer look at the more contentious claim that genetic and psycho-social factors can destroy or seriously damage people's capacity to be morally responsible for their risky choices and the equally contentious claim that "normal" people lack sufficient capacity to be morally responsible even though they are not adversely affected by such factors.

With regard to the second of these claims, the only mental capacity which a large number of regular people might actually lack to any significant degree is the cognitive capacity to understand risks. The medical literature is replete with studies which demonstrate that people have great difficulty understanding basic statistical concepts and anyone who has tried to explain risks to patients or research participants will know just how hard it is to do this successfully (Pailing 2003).

We need to be a little careful here. Just because many people don't understand statistical concepts does not mean that they are not capable of doing so. It is entirely possible that most people have the capacity to understand these concepts but, because they were badly educated – or because they failed to put any effort into improving

their understanding of basic mathematical concepts – their underlying capacity remains “dormant”. On the other hand, it may be that there really is an underlying lack of capacity.

Unfortunately, there is insufficient evidence for us to be sure about this issue.

However, I am ready to concede that a large swathe of people may partially lack the capacity to understand these concepts and I am ready to accept that many people’s degree of moral responsibility is partially diminished as a consequence. Nonetheless, we do not have enough evidence to conclude that most people lack this capacity to a significant degree and so we are entitled, at this point in time, to conclude that people’s degree of moral responsibility is not seriously affected by this problem.

What, then, of the more specific claim that certain genetic and psycho-social factors can seriously diminish people’s mental capacity? The easiest way to approach this claim is to look at each main factor in turn and analyse which mental capacity is affected by these factors. I will begin by looking at the claim that genetic factors can diminish people’s ability to be morally responsible for their risky behaviours and I will then look at the claim that a number of psycho-social factors can do the same thing.

One strand of evidence for the claim that genetic factors can diminish people’s mental capacities is derived from research which suggests that some chromosomal and genetic mutations can increase the probability that people behave in a specific kind of way. For example, there is increasing evidence to suggest that people who inherit certain “MAO-A” gene variants – and people who are born with XYY syndrome – are

more prone to aggression and are more likely to take risks with their health (Witkin et al 1976; Walzer et al 1978; Gotz et al 1999). There is even some evidence to suggest that the CYP2A6 gene affects people's ability to stop smoking and that the A1 allele of the dopamine D2 receptor gene makes it harder for people to stop drinking alcohol (Cloninger 1991; Malaiyandi et al 2005).

There is much debate about the validity of these claims, but even if these specific claims are unfounded, it is reasonable to think that at least some people are born with malformed genes or chromosomes are more likely to engage in risky behaviours. After all, many of our brain functions are partially controlled by genes and it is *prima facie* reasonable to think that malformations in some of these genes will affect the way that we behave. However, we should not automatically conclude that some people will be less morally responsible for their risky choices just because they inherit genes that influence their behaviour. Before drawing such a conclusion we must first have a better idea about which mental capacities are affected by these genetic abnormalities and whether people can do anything about the impact that their abnormal genes have on them.

It is very difficult to work out which mental capacities are affected by which gene malformations. The main claim that is made with respect to most chromosomal and genetic abnormalities is that these abnormalities somehow diminish people's volitional ability to act on the basis of their reasons (Baron 2001). More specifically, the claim seems to be that these genetic abnormalities make it more difficult for people to avoid acting on their desires to take risks even when they can perceive that there are strong reasons to avoid doing so.

I agree with Glannon (2002) that the presence of such genes will not entirely destroy people's ability to respond to reasons.<sup>76</sup> The evidence suggests that those people who are affected by genetic and chromosomal abnormalities often retain the ability to resist taking risks with their health and this suggests that most genetic mutations do not entirely overwhelm people's ability to respond to reasons (Kelley 2005).

Moreover, people affected by these conditions still retain the capacity to take steps to overcome their increased tendency to take risks. For example, there is nothing to prevent people with XXY syndrome from attending psychological therapy classes in order to reduce their tendency to engage in impulsive, risk taking, behaviour.

This does not mean that the inheritance of abnormal genes does not diminish people's capacity to be morally responsible for their risky health affecting choices at all. Some allowance has to be made for the added difficulty that people face as a result of their genetic inheritance. However, I dispute the claim that there is sufficient evidence to think that genetic abnormalities significantly reduce people's capacity to respond to reasons and so I deny that we have good reason to conclude that people who inherit abnormal genes are only marginally morally responsible for their risky health affecting choices.

In addition to the various genetic factors cited above, many commentators also claim that psycho-social factors can diminish people's capacity for moral responsibility. Of these, the most commonly cited factor is "addiction" and the most common claim that is made is that the addictive power of a number of substances damages people's

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<sup>76</sup> The law in many countries take a similar position with respect to legal responsibility. For example, in the case of *Regina v. Newell* (1980) the courts concluded that genetic predispositions could not entirely destroy people's ability to be criminally responsible.

capacity to avoid consuming the dangerous products which contain these addictive substances (Buyx 2008).

There is certainly no doubt that nicotine, ethanol and a number of chemicals found in other recreational drugs have the ability to cause both physical and psychological addiction (Glannon 1998). I also accept that there is some reason to believe that a small number of food products, most notably chocolate, have addictive properties too (Brownwell et al. 2010). But which capacities are affected by addictive substances and should we conclude that people who are addicted are, for this reason, only marginally morally responsible for their drug taking behaviour?

There is a large psychological and psycho-pharmaceutical literature devoted to the issue of how addictive substances actually impact on people's brains and how they reduce people's ability to avoid taking the drug again in the future. The fundamental problem boils down to the fact that addictive substances, like the genetic abnormalities discussed earlier, reduce people's volitional capacity to act on the basis of reasons. More specifically, addictive substances create "*irresistible urges*" which effectively undermine people's ability to use their reason to over-rule their desires to take the drug that they are addicted too (Fischer and Ravizza 1998). Indeed, it is for this very reason that many philosophers argue that addictive substances can diminish people's moral responsibility for taking recreational drugs (Glover 1970).

Addictive substances can damage people's mental capacities by undermining people's volitional capacity to act on the basis of reasons rather than desires. However, there are good reasons to think that most addictions do not entirely destroy people's

capacities to stop taking drugs. Moreover, we have sufficient reason to think that people who are addicted may still, in large part, be morally responsible for their addictive state.

The reasons I make these claims are threefold. Firstly, people's decision to consume addictive substances for the first time cannot be explained by the addictive power of any of these substances. This is obviously something of a truism, but it is worth pointing out because it means that even if people's mental capacities to resist taking addictive substance is later reduced by the addictive properties of these substances they may still be entirely morally responsible for choosing to take the drug in the first instance. We have to recognise that many people start experimenting with drugs when they are children (Leslie 2008). Consequently, some people will become addicted long before they are old enough to be morally responsible for their actions. However, this is not always true and in the case of people who start taking drugs as adults this latter excuse simply does not apply.

Secondly, some addictive substances like alcohol have to be consumed for many years before they become addictive (Glannon 2002). This is important because it means that the claim that people cannot be morally responsible because they started consuming drugs when they were children does not always hold water. Indeed, Dietrich (2002) suggests that we can sometimes regard people as morally responsible for becoming addicted even when they started taking drugs as children because, at least with respect to some drugs, people have sufficient time to stop consuming these drugs (as adults) before addiction sets in. This is especially true when the people concerned have plenty of opportunity to seek help from health care professionals who

can offer medications and psychological therapies to enable people to wean themselves off drugs before they become addicted to them (Wikler 1987).

Thirdly, even when people are addicted to a drug this does not mean that they lose the capacity to do anything about their addiction. A whole range of different support groups are now available to help people “break” their addictions (e.g. Alcoholics and Narcotics Anonymous) and many medical drugs, such as methadone and nicotine patches, are available to help people manage the addictions that they do have. This is important because, as Dietrich (2002) argues, we may reasonably regard people as largely morally responsible for their ongoing addiction if they do not make any efforts to “*enter therapy*” or “*join one of the numerous self help groups*” which are available to those who are addicted.

In sum, then, we should conclude that addictive substances really can diminish or destroy people’s ability to act on the basis of reasons and that, for this reason, they have the power to diminish people’s degree of moral responsibility in relation to their risky drug taking behaviour. However, I also think that we have good reason to think that many people who are addicted are substantially morally responsible for their risky behaviours.

Yet another common claim that is made in relation to “responsibility diminishing” psycho-social factors is the claim that the way in which certain risky products are marketed diminishes people’s capacity to avoid consuming these products. In particular, it is claimed that the way in which the tobacco, alcohol and food industries’ advertise their products undermines people’s capacity to avoid smoking, drinking and

eating unhealthy food (Buyx 2008). Of course, advertising has a positive side because it informs people of the various options available to them. However, we now know that the goal of most advertising is to subvert our normal reasoning process.<sup>77</sup> For example, most modern adverts use affective conditioning techniques to encourage consumers to transfer the positive feelings that they naturally have about some concepts or objects or ideas (e.g. sex or sunshine) to the product that is being sold (Markman 2010).

Certain forms of advertising, such as subliminal advertising, have even been banned in many countries because of their power to subvert rational thought and some dangerous products, such as tobacco, can now only be advertised in a limited number of ways in most developed countries (Benjamin and Baker 2004). Nonetheless, even with these prohibitions in place, it is often argued that the ubiquity and nature of most forms of advertising diminishes people's moral responsibility for some of their health affecting choices (Brownell 2010).

There seems to be good reason to think that advertising can partially diminish people's capacity to act on the basis of reasons rather than on the basis of their desires. Given that this is exactly what most forms of advertising are designed to do – and given how large marketing budgets are – it would be hard to argue otherwise.

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<sup>77</sup> Many of the pioneers of commercial advertising were psychologists who specifically set out to devise and use a variety of psychological techniques to influence consumer's choices and advertisers now routinely make use of many psychological techniques to exploit our weaknesses in order to encourage us to purchase products. For example, one of the earliest advertisers, Walter Dill Scott argued that "*man has been called the reasoning animal but he could with greater truthfulness be called the creature of suggestion*" because he realised that human beings were heavily affected by simple advertising techniques which were designed to act on our emotions rather than our reasons (Benjamin & Baker 2004).



However, with the exception of subliminal form of advertising, most marketing techniques do not have the power to seriously diminish our mental capacity to respond to reasons or our ability to be substantively morally responsible for our risky choices. Part of my reason for saying this is because most people are now wise to the purpose and power of advertising which means that they can take measures to counteract the effects that advertising would otherwise have. Indeed, I believe that most human being have the power to consciously ignore the underlying associations that advertisers rely on to over-rule our reason.

The last factor that many people refer to as having the power to diminish our mental capacities – and thus our ability to be morally responsible for our risky health affecting choices – is, perhaps, the most complex to understand and explain. This factor can be best described as “upbringing”, but it refers to more than just the way we are brought up by our parents. It also refers to the impact that our peers have on us and the way in which general social forces – such as socio-economic class – influence our way of seeing the world.

The basic claim that is made in these cases is that certain dysfunctional or maladaptive experiences make it more likely that people will take risks with their health both when they are children and, more importantly, when they are adults. For example, being brought up by very abusive parents increases the probability that people will self harm later in life (Mina and Gallop 1998). Likewise, a number of researchers have argued that people who grow up in lower socio-economic groups are more likely to engage in risky health affecting behaviour as adults (Marmot 2004; Wilkinson and Pickett 2009). But how do these various psycho-social forces affect

our mental capacities and do they undermine people's moral responsibility for their choices?

The way in which these kinds of psycho-social forces affect our capacities in later life is extremely complicated, but it seems clear that these factors can affect our volitional, cognitive, conative and affective capacities to some degree. For example, children who are brought up in very abusive families may well have a diminished desire to be healthy, a diminished capacity to identify emotionally with their choices, a diminished capacity to perceive reasons for avoiding risky behaviours and a diminished capacity to act on the basis of reasons rather than their desires. Indeed, a very abusive upbringing can probably skew people's understanding of the world so severely that they simply cannot perceive the kinds of reasons that other people perceive or desire the kinds of desires that other people desire.

However, we cannot say the same of the more ubiquitous psycho-social factors that affect our upbringing. For example, people who are born in social class IV or V cannot seriously argue that their socio-economic milieu damaged any of their mental capacities. This is not because people born into these social classes are completely unaffected by the fact that fellow members of their socio-economic group are more likely to smoke, drink excessively, take drugs and eat unhealthy foods.

Rather, it is because these factors do not seriously undermine any of their volitional, cognitive, affective or conative capacities. Being born into social class V, for example, does not significantly undermine people's capacity to act on the basis of reasons or their capacity to desire their own health. Moreover, people's ability to

reflect on what they are doing and to make adjustments when they realise that they are being influenced by these wider social group seems undimmed regardless of which socio-economic group people are born into.

As such, though I accept that an abusive upbringing can seriously diminish people's moral responsibility for their risky health affecting choices the same is not true of other aspects of people's upbringing. In particular, adults cannot realistically claim that their degree of moral responsibility for their risky health affecting choices is diminished just because they were born into a lower socio-economic group.

### **5.1.3 The mental capacity condition: conclusion**

In conclusion, there is good reason to think that some people's degree of moral responsibility is seriously diminished because they lack some mental capacity. In particular, children and people suffering from serious brain injuries or serious mental health problems are exempt from claims about moral responsibility and that other people's degree of moral responsibility can be partially affected by a range of genetic and psycho-social forces. I would also add that many of these factors can combine together to significantly diminish people's mental capacities. However, in the majority of cases, people's relevant mental capacities remain intact throughout their lives and so the common intuition that most people have sufficient mental capacity to be morally responsible for their risky choices is correct.

## 5.2 The freedom condition: introduction

Aristotle (1984) was in no doubt that an agent needed to be acting “voluntarily” in order to be the proper subject of praise or blame and few have ever countermanded the idea that some sort of freedom is necessary for moral responsibility (Glover 1970; Fischer and Ravizza 1998; Glannon 2002). However, this consensus about the necessity of freedom belies a complex set of disagreements about the meaning of freedom, the kind of freedom that is necessary for moral responsibility and whether, and to what extent, the relevant kind of freedom actually exists. Indeed, Yoder (2002) argues that “*at a theoretical level we lack any consensus [about] a philosophically adequate notion of free will*”.

Unfortunately, I do not have the space in this thesis to fully explore why this consensus is lacking, but it is impossible to seriously engage with the question of whether people are morally responsible for their risky behaviour without discussing whether people are sufficiently free to be morally responsible for their choices.

Bearing these two points in mind, my goals in this section will be as follows. Firstly, I will provide an overview of the various interpretations of the kind of freedoms that philosophers have thought necessary for moral responsibility. Secondly, I will explain which of these interpretations I find most convincing. Thirdly, I will discuss whether we have good reason to think that people really are free to make choices about their risky health affecting behaviours. My discussion of these issues will necessarily be brief, but I hope that the analysis will, nevertheless, prove to be useful and will

convince people that the majority of human beings are sufficiently free to be morally responsible for their risky health affecting choices.

### **5.2.1 What kind of freedom is necessary for moral responsibility?**

Of all the disagreements that exist between philosophers who write about the concepts of free will and moral responsibility, the disagreement about which type of freedom is necessary for moral responsibility seems to be one of the most intractable. There are two broad schools of thought on this matter. On the one hand, there are philosophers (known as incompatibilists) who believe that the freedom necessary for moral responsibility is the “*ability to do otherwise*” (Van Inwagen 1983; Kane 1994). What this means, in a technical sense, is that people can only be free if their future is not determined (Watson 1987). On the other hand, there are philosophers (known as compatibilists) who argue that the kind of freedom which is necessary for moral responsibility has nothing to do with the ability to do otherwise (Frankfurt 1989; Fischer 1994).

Unfortunately, different compatibilists define and describe the concept of “compatibilist freedom” in different ways and so there is no single doctrine of compatibilism. The traditional way of construing compatibilist freedom states that people are free as long as they are not acting as a result of some kind of external coercion (Glannon 2002). For example, Hume (1987) suggests that if people act of “*necessity*” as a result of some kind of force or constraint then their “*liberty of spontaneity*” (i.e. their freedom) is destroyed.

In more recent times, compatibilists have taken rather different approaches. Watson (1987), Fischer and Ravizza (1998) and Wolff (1998) have all argued that people can be free as long as they are able to “*respond to reasons*”, whilst Frankfurt (1971) has defended a “*hierarchical model*” of freedom.

The former approach is fairly self explanatory although there is much debate about how responsive to reasons people need to be and which set of reasons people must be responsive to in order to be morally responsible. Watson (1987) and Wolff (1998) argue that people can only truly be said to be free if they can specifically respond to value based reasons, whilst Fischer and Ravizza (1998) take a less normative stance and argue that people are free as long as they can perceive reasons for – and against – acting in a certain way and can act on the basis of these reasons.

The hierarchical model, meanwhile, states that a person has freedom of will when he wills what he wants to will and he has freedom of action when he is able to act according to his will (Frankfurt 1992). In other words, a person is free when his first order desires are in conformity with his second order volitions. Frankfurt (1971) also argues that a person can only be free and morally responsible if they identify, or decisively identify, with their desires.

Of these very different compatibilist and incompatibilist conceptions of freedom the traditional (“no coercion”) compatibilist conception is the best way of understanding what freedom really means and the best way of conceptualising the kind of freedom which is necessary for moral responsibility. I do not have the space to delve into all the reasons why I think that this is the case here. However, I will briefly explain my

primary reasons for rejecting some of the other, compatibilist, conceptions of freedom.

The key problem with the hierarchical account is that this argument seems vulnerable to an infinite regress (Zimmerman 1981). There is no *prima facie* reason to think that we should stop at the second order level when determining whether people are free and so we could argue that people are only free when their first order desires are in conformity with their third, fourth, fifth (etc.) order volitions. Frankfurt's account is also vulnerable because people's higher order volitions could be induced by a coercive element. This is problematic because we surely would not want to conclude that, in these cases, people are nevertheless free (Stump 1988). I am also not convinced that people who fail to identify with their desires are, for this reason, lacking in freedom. Certainly, it is important that people are able to emotionally identify with their desires if they are to be morally responsible. But this ability is best described as a mental capacity rather than a form of freedom.

The problem with the "reasons responsiveness" conception of compatibilist freedom is that it also misclassifies the importance of reasons responsiveness for moral responsibility. In other words, it makes more sense to regard reasons responsiveness as a *mental capacity* than as some kind of freedom. The reason why this is the case is because acts of coercion do not always undermine people's ability to respond to reasons and, if this is true, it suggests that a "reasons responsive" compatibilist would not regard coercion as a "freedom diminishing" factor. This, in turn, is problematic because it is deeply counter-intuitive to claim that coercion does not undermine

freedom. Moreover, few “reasons responsive” compatibilists would want to draw this kind of conclusion.

A “reason responsive” compatibilist might object by arguing that coercion does undermine people’s ability to respond to reasons in each and every case. However, although I accept that in *some* cases people who are being coerced do lose their ability to respond to reasons I do not think that this happens in every case.<sup>78</sup> The reason why most people make “rational” choices when they are coerced (e.g. by handing over money to an armed robber rather than crying hysterically and trying to wrest control over the robbers weapon) is precisely because they can still respond to reasons.<sup>79</sup>

To some extent this may be a matter of semantics. Fischer and Ravizza (1998) and Glannon (2002) slip between talking of the inability to respond to reasons as a failure of mental capacity and talking of this inability as a lack of freedom. Moreover, I entirely agree with them that reasons responsiveness is necessary for moral responsibility. However, even if this is ultimately a semantic rather than a substantive issue, it is easier to separate the two issues and regard acts of coercion as an attack on our freedom and a lack of ability to respond to reasons as a problem with our mental capacities.

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<sup>78</sup> People might lose the ability to respond to reasons if the coercion is overt and so threatening that people lose the ability to deliberate and act on the basis of reason as a result of being “paralysed” with fear.

<sup>79</sup> It may also be argued that the problem with coercion is that it undermines people’s ability to respond to their “own” reasons. However, I am not convinced that this is the right approach either. After all, if someone is coerced it is not clear that they are, by definition, acting on other people’s reasons or on reasons that they cannot identify with. Moreover, if we think that this is the case we might prove too much for we often act on the basis of other people’s reasons even when we are not being coerced.



### **5.2.2 Are we sufficiently free to be morally responsible for our risky health affecting behaviour?**

It should be clear that whether we really are sufficiently free to be morally responsible for our risky health affecting behaviour depends on what kind of freedom we think is necessary for moral responsibility as well as whether we think that this kind of freedom actually exists in the real world. Once again, incompatibilists and compatibilists (of all stripes) are divided over this issue.

Incompatibilists of a “hard determinist” persuasion think that the thesis of causal determinism is true and thus they argue that people lack freedom because they lack the ability to do otherwise than they actually do. Incompatibilists who adopt the philosophical thesis known as “metaphysical libertarianism”, on the other hand, argue that causal determinism is false and most of them also claim that people are free because they have the ability to do otherwise. Compatibilists, meanwhile, generally believe that people are free – in the compatibilist rather than the “ability to do otherwise” sense – but it is entirely possible for any kind of compatibilist to argue that people are not free at all. For example a “reasons responsiveness” compatibilist might defend the claim that people always lack the ability to respond to reasons and, on this basis, conclude that no one is ever free.

I do not intend to engage with the long standing debate about whether or not people are free in the “ability to do otherwise” sense here. Personally, I think it is very hard

to understand what it would mean for people to free in this particular sense.<sup>80</sup> It is also unclear how metaphysical libertarians can make sense of the casual forces that seem to have systematic effects on our choices.<sup>81</sup> However, though I will not try to solve this perennial question here I do want to say a few words about the implications of adopting the metaphysical libertarian and hard determinist position from the point of view of moral responsibility before I analyse whether people are free from the compatibilist perspective.

Those who adopt the metaphysical libertarian position generally argue that people are morally responsible. This is because metaphysical libertarians believe that the world is not causally determined and most of them think that human beings have the ability to do otherwise. They also generally argue that people are able to do otherwise in a rather “complete” kind of way. This is because, from their perspective, people’s will is entirely untrammelled by causal forces and so people’s choices are entirely unconstrained. Consequently, they regard people as free in a rather absolute sense. Those who adopt the hard determinist position, on the other hand, will draw the exact opposite conclusion. They will argue that people cannot be free or morally responsible *at all*. This is because they believe that everything in the world is causally

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<sup>80</sup> Chisholm (1967) argues that people can only be free in this sense if they are “*prime movers unmoved*”, but it is not easy to understand what this really means, never mind believe that human beings actually possess this capacity.

<sup>81</sup> For example, we know that people born into lower socio-economic groups are more likely to smoke than people born into higher socio-economic groups. But if causal forces do not impinge on people’s decisions to engage in risky behaviours it is hard to make sense of this evidence. If we accept that causal forces can determine behaviour then we can say that social class is, partially, causally responsible for the way in which people behave. In other words, we could explain the data about smoking and social class. But if we deny that causal forces can play this role the systematic differences in risky behaviour between social groups seems impossible to understand.

determined and this necessarily implies that the ability to do otherwise is impossible – in which case metaphysical freedom is a mere chimera.

The compatibilist position is more complex. As I noted above, most compatibilist argue that people are free, but they also concede that “*there are many degrees of freedom of choice*” and that people’s degree of moral responsibility varies accordingly (Buyx 2008). However, there is little agreement between different compatibilists about how free (and morally responsible) people really are. This is partly because different compatibilists understand the concept of freedom differently, but even those who are in agreement about the concept of freedom disagree about the extent to which their preferred conception actually obtains in the real world. For example, Frankfurt (1992) believes that many drug addicts are free because they identify with their first order preferences to take the drugs that they are addicted too. However, people who adopt the reasons responsive approach tend to argue that most drug addicts are not free because addictive substances destroy people’s ability to respond to reasons (Fischer and Ravizza 1998).

I have argued above that the best interpretation of compatibilist freedom is the “no coercion” interpretation. In other words, I have suggested that people are free as long as they are not being coerced by other people. Importantly, if we adopt this particular conception of compatibilist freedom, we can argue quite easily that, in the vast majority of cases, people are sufficiently free to be morally responsible for their choice to engage in most risky behaviour from the perspective of the freedom condition. The simple reason for this is because most people are not coerced into

making the risky choices that they make; very few people who smoke or scuba dive or sunbathe excessively are coerced into taking these risks.

This is not to say that there are no exceptions to the rule. At the extreme end, there are many examples of women (and men) being forced to have unprotected sexual intercourse. Rape is a relatively common phenomenon and we should not forget that a small, but important, number of women are effectively coerced into being prostitutes (and coerced into having risky sex) too. At the less extreme end it may be argued that some teenagers (and some adults) are put under a huge amount of pressure from their peers to smoke, drink or consume recreational drugs.<sup>82</sup>

However, although I accept that there are legitimate exceptions, it does not make sense to say that (non subliminal) forms of advertising, addictive substances, abnormal genes and many other psycho-social factors described earlier act as *coercive* forces. Thus, we can conclude that the vast majority of people are free and morally responsible for their risky health affecting behaviour – at least from the perspective of the “no coercion” conception of compatibilist freedom.

I would also like to add at this point that those who adopt the reasons responsiveness and hierarchical approaches to compatibilist freedom are likely to agree that most people are sufficiently free to be morally responsible for their risky health affecting choices. This is because, as I have argued in the previous section, there is good reason to think that most people have the capacity to be able to respond to reasons and, in particular, the capacity to act on the basis of reasons to remain healthy rather than

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<sup>82</sup> I do not think that all cases of peer pressure amount to coercion, but I concede that peer pressure can be sufficiently intense to constitute coercion.

desires to take risks. They also, in most cases, have the capacity to identify with their first order desires. However, if we adopt the reasons responsiveness or the hierarchical approaches we are also likely to argue that people are less free than they are from the perspective of the “no coercion” approach to freedom. This is because a whole range of different factors which do not “coerce” people nonetheless impact on their ability to respond to reasons and their ability to identify with their first order desires.

### **5.2.3 The freedom condition: conclusion**

In conclusion, there is good reason to think that most people are sufficiently free in order to be morally responsible for their risky health affecting behaviour. I have not tried to prove that causal determinism is true or that metaphysical libertarianism is false. Such matters would take me far beyond the limits of this thesis. Likewise, I have only given a very brief overview of the many different compatibilist approaches to freedom and I have only hinted at the reasons why the “no coercion” conception of freedom is correct.

This means that my account of the freedom condition and the conclusions that I have drawn here are vulnerable to a range of counter-arguments that I have not even mentioned, never mind responded to. Nonetheless, my disagreement with the reasons responsive compatibilists is unlikely to amount to much given that I agree with them about the importance of this capacity from the perspective of moral responsibility and although metaphysical libertarians and hard determinists will not be impressed I can

at least appeal to the fact that there is evidence to suggest that the vast majority of contemporary philosophers believe that some form of compatibilism is correct.<sup>83</sup>

### **5.3 The epistemological condition: introduction**

The idea that individuals need to have access to least some information in order to be able to make rational, informed, decisions and in order to be morally responsible for their actions is familiar to us all. The idea that ignorance, in certain circumstances, can excuse some behaviour and render ascriptions of moral responsibility meaningless is also a very common intuition.<sup>84</sup>

In the philosophical tradition there has also long been recognition of the fact that knowledge and moral responsibility are intimately linked and that ignorance may reduce, or even entirely nullify, moral responsibility (Fischer and Ravizza 1998). Aristotle (1984) argued that in order to be morally responsible for his actions a man needed to know: (i) what he was doing, (ii) who he is, (iii) what (or whom) he is acting on, (iv) what instrument he is acting with, (v) his purpose, and (vi) how he is performing his act. He also defended the idea that ignorance can excuse people from ascriptions of praise and blame.

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<sup>83</sup> Chalmers (2009) asked philosophers whether they “accepted” or “leant toward” either “compatibilism”, “libertarianism”, or a position he described as “no free will”. Of 931 respondents, 59% noted that they accepted or leant towards compatibilism, 13.7% accepted or leant toward libertarianism and only 12.2% accepted or leant toward “no free will”. 14.9% of respondents gave another answer or did not answer the question.

<sup>84</sup> If a man who was blind from birth walked into a minefield because he could not see the warning signs it is hard to believe anyone would judge the man to be morally responsible for his risky choice.

Most contemporary philosophers agree with Aristotle that people must know – or have access to – certain types of information in order to be morally responsible and that ignorance, in certain situations, can undermine ascriptions of moral responsibility (Glover 1970; Scanlon 1998).

The law has also traditionally placed great emphasis on the importance of knowledge and access to information when making judgments about civil and criminal responsibility. For example, the M’Naghten test specifically states that an individual may be excused from ascriptions of criminal responsibility if he did not “*know the nature and quality of the act he was doing...or he did not know that what he was doing what was wrong*” for reasons of mental insanity (Elliot 1996). Glannon (2002) argues that the knowledge condition of responsibility features more prominently than either the freedom or the mental capacity condition when courts of law try to determine whether individuals can be regarded as criminally responsible for their actions.<sup>85</sup>

However, though the epistemological condition has long been regarded as vitally important for moral (and legal) responsibility, relatively little analysis of this condition has been carried out by philosophers. Of the many works that have been published on the topic of moral responsibility in the last few decades, for example, the vast majority have concentrated solely on the freedom or the mental capacity

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<sup>85</sup> In the context of the civil law in England and Wales, a patient’s consent for treatment will be deemed legally invalid if it is thought that the patient was not sufficiently informed about the treatment to which they were giving their consent (Herring 2010). In other words, the law sets a very high premium on patients being provided with relevant information if they are later to be treated as responsible for their health care choices.

conditions of moral responsibility.<sup>86</sup> Moreover, in the medical and bioethical literature on personal responsibility for health virtually no explicit mention is ever made of the epistemological condition – although a few experts do mention the issue in passing (Buyx 2008; Golan 2010).

In this section I will not attempt to provide an extensive analysis of the epistemological condition, but I will discuss a number of practical issues which are germane to the question of whether this condition obtains in relation to risky health affecting behaviour.

I will begin by describing the kind of information that people need to have access to in order to make reasoned, informed, decisions and I will analyse how accessible and readily comprehensible this information needs to be if people are to be morally responsible for their risky choices. I will then discuss whether this information is sufficiently accessible and sufficiently comprehensible for people to be morally responsible for their risky health affecting choices in the real world. Finally, I will discuss the distinction between culpable and non-culpable ignorance and I will try to elucidate how many people can claim to be genuinely non-culpably ignorant given the background assumption that relevant information is sufficiently accessible and sufficiently comprehensible.

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<sup>86</sup> Fischer and Ravizza (1998), in their highly influential monograph on moral responsibility, almost entirely ignore the epistemological issue and relegate the discussion to a footnote where they simply say: “*we shall assume that our analysis can be supplemented with a component that would attend to the epistemic condition on responsibility*”.



### **5.3.1 What kind of information do people need access to in order to be morally responsible for their risky health affecting choices?**

If we accept that people cannot be morally responsible for their health affecting behaviours unless they have access to at least some information we need to determine what type of information people need to have access to how accessible and comprehensible this information needs to be.

With regard to the first issue, the first thing to note is that there is a limit to the type of information that people need to possess in order to rationally deliberate about the choices that they make. It is also worth bearing in mind that many governments and health care organisations have issued guidelines which are designed to help health care professionals determine what “type” of information patients need access to if they are to be able to make informed choices about their health care (General Medical Council 2008). Thus, if we bear the first point in mind and make judicious use of the various guidelines that have previously been published it should be possible to construct a list of the kind of information that people need access to in order to be morally responsible for their choices. Such a list – which is not intended to be exhaustive – but which is intended to cover all the key information that people need access to, can be found in Figure 4.0 below.

**Figure 4.0. The Type of Information Needed for Moral Responsibility in Relation to Risky Behaviour.**

<b>Type of Information</b>	<b>Explanation</b>
The nature of the behaviour	To include both the “metaphysical” and the “normative” nature of the behaviour.
The reasons for engaging in the behaviour	To include both the potential benefits and the potential costs of engaging in the behaviour
The nature of any disease that might be caused by the behaviour	To include both the symptoms of the disease(s) and the severity of the disease(s) caused by the behaviour
The social and psychological consequences (for the patient) of developing any disease which might be caused by the behaviour	To include both the general psychological and social effects of having an acute/chronic disease as well as more specific problems (e.g. the impact of social stigma if the disease typically carries such a stigma)
The potential complications of any disease that might be caused by the behaviour	To include the physical and psychological complications which may be caused by the disease(s) caused by the risky behaviour
The probability of harm and benefits occurring if people engage in a risky health affecting behaviour	To include an understanding that probability is hard to determine and that each individual faces a different (and partially unknowable) risk
The nature, cost and availability (if any) of the investigations and treatments for any disease (or complication of disease) which might be caused by the behaviour	To include an understanding of the duration of these investigations and treatments and any common side effects associated with them
The impact that the behaviour (and any disease caused by the behaviour) might have upon other people	To include the impact our decision might have on other people’s access to health care both now and in the future

I hope that this table is fairly self-explanatory and that it is obvious why people need access to the kind of information that I have listed above in order to be morally responsible for their risky health affecting choices. Of course, one might want to dig a little deeper and ask why it is that people need access to *any* information in order to be morally responsible for their choices. Indeed, one might want to ask why there is an epistemic condition of responsibility in the first place.

Some theoretical account of the epistemological condition is ultimately needed and such an account would help to inform decisions about the kind of information people need access to in order to be morally responsible.<sup>87</sup> However, a thoroughgoing theoretical account of the epistemological condition has not yet been produced by normative philosophers and I will not develop my own account here. Nevertheless, this lack of theoretical groundwork does not mean that we cannot say anything useful about the kind of information that people need access to in order to be morally responsible for their risky choices. In the absence of such a theoretical account it is legitimate to use common sense intuition – and common practice – to construct precisely the kind of list that I have constructed above as long as we accept that this list may need to be revised in light of future theoretical developments.

Even if we accept that this is the case we still need to determine how accessible and how comprehensible this information needs to be if we are going to claim that people have sufficient access to sufficiently comprehensible information to be morally responsible for their choices. Once again, the lack of a thoroughgoing philosophical account of the epistemological condition makes this task very difficult. However, Scanlon (1998) has made some attempt to create a theoretical framework with respect to the issue of how far governments have to go to warn their citizens about various risks and his account can be utilized to frame the discussions about the degree of

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<sup>87</sup> The underlying basis of the need for an epistemological condition probably has much to do with the fact that people cannot deliberate rationally, or respond to reasons, or bring their values to bear on the choices that they make unless they have access to some relevant information. In other words, the epistemological condition is necessary because without access to information the mental capacities that are themselves necessary for moral responsibility cannot gain traction in the real world.

accessibility of information that is needed if people are to be morally responsible for their risky health affecting choices.

According to Scanlon's "*Value of Choice*" account of moral responsibility, there is a limit to how much effort governments must expend in trying to warn their citizens about certain risks. He claims that, at a certain point, officials can legitimately argue that they have "*done enough*" because people "*cannot reasonably reject*" the contractualist principle that a governments' duty, in this respect, is necessarily limited (Ibid, p 258). In other words, governments can justifiably limit the amount of effort they expend warning people about risks on the basis that people cannot reasonably reject this claim. Scanlon also gives a practical account of what this might mean in practice when he discusses the issue of how far governments would have to go to warn residents about the movement of hazardous waste from one location to another (Ibid, p 258).

If we adopt the general idea that there is a limit to how much effort governments must expend in warning their citizens about certain risks and if we also adopt the Scanlonian rationale for this claim – i.e. that this limit can be justified on the basis that people cannot reasonably reject this claim – what lessons can we draw about how accessible and comprehensible information about risky behaviour needs to be if people are to be deemed morally responsible for their ignorance?

It is not easy to say, but I think that the following claim is justifiable on the basis of Scanlon's ideas: the information listed in the table above can be deemed sufficiently accessible and sufficiently comprehensible if (a) people conducting a simple online

search using basic words (such as “risks of smoking” or “information about alcohol”) will be directed to at least one website in the “top ten” search results which provides relevant information in a form which is jargon free and comprehensible to an average 16 year old child, (b) health care professionals are readily available to provide more details and (c) simple warnings about common risks are regularly issued by governments using an array of different advertising techniques (e.g. television announcements and billboard signs).

It is an open question whether Scanlon would accept this particular specification and many philosophers who are sympathetic to Scanlon’s ideas might entirely disagree with my claim. However, my approach does gel with the spirit of Scanlon’s approach because, if the information listed in table 1.0 was available in the way that I have described above, then most people could not reasonably claim that they lacked sufficient access to sufficiently comprehensible information to be morally responsible for their risky health affecting behaviour. Furthermore, my practical approach fits well with common sense intuition about this matter.

### **5.3.2 Do people have access to the information that they need?**

I have argued above that people need to have access to certain types of health information in readily accessible and easily comprehensible forms in order to be morally responsible for their risky health affecting choices. I have also tried to define what kind of information is needed and how readily accessible and easily comprehensible this information needs to be. But do people actually have sufficient access to sufficiently comprehensible health information?

My answer, in short, is that they usually do. In other words, the epistemological condition does obtain in most cases of risky health affecting behaviours and we should regard most people as morally responsible for their risky behaviour – at least from the perspective of the epistemological condition. My primary reason for making this claim is that, over the last few decades, most developed world governments (alongside a whole host of other non-governmental organizations) have made concerted efforts to raise people's awareness of public health issues. In particular, these governments have launched an array of public health campaigns which have made use of many different forms of advertising to warn people about the risks of many of the more common risky health affecting behaviours.<sup>88</sup> Furthermore, they have tried to ensure that health care professionals are properly trained to provide health information to patients and they have provided a wealth of information online via easily accessible and readily comprehensible websites.

If we take smoking as an example we can see that the amount of readily available and easily comprehensible information about this particular risky behaviour is colossal. A simple search using the Google search engine for the terms “smoking and disease” reveals a staggering 37,100,000 results.<sup>89</sup> Some of the results contain links to websites containing fairly esoteric information, but many of them provide a great deal of information about most of the relevant aspects of smoking in an easily accessible and comprehensible fashion. The first 10 websites which were highlighted in my search all contained information which was easy to understand and eight of the ten websites

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<sup>88</sup> They have even, in some cases, required the companies who sell dangerous products (e.g. tobacco and alcohol) to place warning information about the dangers of these products on their packaging.

<sup>89</sup> This search was conducted on 20<sup>th</sup> November 2010.

included information which was specifically designed for the general public (see Figure 5.0 for the results).<sup>90</sup>

**Figure 5.0 Top Ten ‘Google’ Hits for Search Terms: ‘Smoking and Disease’.**

Source	Website Address
Net Doctor	<a href="http://www.netdoctor.co.uk/health_advice/facts/smokehealth.htm">http://www.netdoctor.co.uk/health_advice/facts/smokehealth.htm</a>
Patient.co.uk	<a href="http://www.patient.co.uk/health/Smoking-The-Facts.htm">http://www.patient.co.uk/health/Smoking-The-Facts.htm</a>
Can Stop Smoking	<a href="http://www.canstopsmoking.com/smoking-facts/effects-smoking.htm">http://www.canstopsmoking.com/smoking-facts/effects-smoking.htm</a>
BBC	<a href="http://news.bbc.co.uk/1/hi/health/4377928.stm">http://news.bbc.co.uk/1/hi/health/4377928.stm</a>
The Family GP website	<a href="http://www.thefamilygp.com/is-smoking-a-disease.htm">http://www.thefamilygp.com/is-smoking-a-disease.htm</a>
Quit Smoking Campaign	<a href="http://www.quit-smoking-stop.com/smoking-diseases.html">http://www.quit-smoking-stop.com/smoking-diseases.html</a>
British Heart Foundation	<a href="http://www.bhf.org.uk/keeping_your_heart_healthy/preventing_heart_disease/smoking">http://www.bhf.org.uk/keeping_your_heart_healthy/preventing_heart_disease/smoking</a>
ASH	<a href="http://www.ash.org.uk/files/documents/ASH_110.pdf">http://www.ash.org.uk/files/documents/ASH_110.pdf</a>
Oxford University	<a href="http://www.ox.ac.uk/media/news_stories/2009/090918_3.html">http://www.ox.ac.uk/media/news_stories/2009/090918_3.html</a>
Wikipedia	<a href="http://en.wikipedia.org/wiki/Tobacco_smoking">http://en.wikipedia.org/wiki/Tobacco_smoking</a>
British Medical Journal	<a href="http://www.bmj.com/content/329/7459/200.abstract">http://www.bmj.com/content/329/7459/200.abstract</a>

It is also increasingly common practice for health care professionals in the UK to routinely ask all their patients about their smoking habits and to provide advice to smokers about the risks of smoking.<sup>91</sup> Moreover, public health campaigns about the dangers of smoking are now ubiquitous and, in many developed countries, including

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<sup>90</sup> I accept that not everyone has access to the internet at home and that this is especially true of the poorer echelons of society. However, internet access is now widespread in the developed world and, in the UK at least, libraries and some other public institutions provide free access to the internet. Moreover, internet access is now available in numerous “internet shops” at a relatively cheap price. People who lack access to the internet also have the option to seek help from health care professionals in the UK and in many other developing countries.

<sup>91</sup> The National Institute of Clinical Health and Excellence (2008b) has recently published guidelines which advises doctors to remind their patients about the health benefits of smoking cessation “*at every opportunity*”.

the UK, tobacco companies have been forced to place warning labels on cigarette packs to remind smokers of the dangers of their habit. Hence, in the case of smoking there is good reason to think that people have access to all the information that they need in order to be morally responsible for their choices to smoke from the perspective of the epistemological condition.

What is true of smoking is also true of many other risky behaviours too. Simple online searches of most of the risky health affecting behaviours that I discussed in the last chapter lead to a range of websites in the “top ten” search results which provide a great deal of easily comprehensible information. Moreover, in the case of many of these behaviours developing world government have gone to great lengths to warn people about the risks of engaging in these behaviours using leaflets, advertising and, in some cases, warning labels.<sup>92</sup> Health care professionals are also increasingly advised to take a proactive approach towards telling their patients about the dangers of risky behaviours like excessive alcohol consumption, excessive sunbathing and unprotected sexual intercourse. Thus, we have good reason to believe that, from the perspective of the epistemological condition, people can be morally responsible for engaging in a wide range of risky health affecting behaviours in addition to smoking.

There are, however, at least two reasons why we might think that people do not have access to all the information that they need. The key problem is that people do not currently have access to much information about the probability of developing a disease if they partake in a risky behaviour or about the impact that their risky

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<sup>92</sup> For example, in the UK citizens are regularly warned about the dangers of alcohol and certain foods via warning labels placed on these products and also via advertising campaigns



behaviour might have upon other people.<sup>93</sup> The reason for this is because most public health campaigns and popular websites either fail to mention these issues or skirt around them. Moreover, although health care professionals do provide information to patients about the probability of developing diseases, they rarely do so in any depth and they almost never discuss the impact that risky behaviour may have on other people.

I accept that there is a relative paucity of information about these issues currently available and this does mean that people's degree of moral responsibility is diminished as a result. However, an increasing number of websites do provide information about the costs that accrue to others when people take risks. For example, a number of UK based websites provide information about the costs of certain diseases to the NHS and, indeed, to the wider UK economy.<sup>94</sup> An increasing number of websites also provide basic information about the incidence and prevalence of diseases and some discuss the mean probability of developing a disease if people engage in certain risky behaviours. Thus, things are slowly improving and I think that there is now sufficient information available for us to conclude that people's degree of moral responsibility is not substantially diminished by the relative paucity of information about these issues (Cummings et al 2004).

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<sup>93</sup> Golan (2010) argues that a lack of information about the latter of these requirements means that patients are often unaware of the "*probable financial impact of their habits on societal resources*".

<sup>94</sup> The website of Diabetes UK is a good example.

### 5.3.3 Culpable and non-culpable ignorance

One might have assumed that the vast increase in the amount and availability of health information would have quickly led to an equally significant increase in people's understanding of risky behaviour and Kelly (2005) is, to an extent, right to claim that "*knowledge of the consequences of [risky] behaviours is now more widely known, thanks to public health initiatives, advertising and education*". However, the level of understanding of risky behaviour has failed to keep pace with the amount of information that is available.<sup>95</sup>

People's knowledge about smoking is an excellent case in point. Most of the surveys relating to people's knowledge about smoking confirm that the vast majority of smokers have some notion that smoking poses a threat to their health. For example, a survey conducted by Hammond et al. (2006) discovered that the vast majority of smokers understood that smoking was, in some sense, risky. However, many other studies have shown that smoker's understanding of the risks of smoking is lamentably poor. A study conducted in the United States showed that the only smoking induced disease that could be identified by a clear majority of smokers was lung cancer and only a small minority could identify the association with Chronic Obstructive Pulmonary Disease or any form of cardiovascular disease (Weinstein et al. 2003).<sup>96</sup> Such is the scale of the lack of awareness that the authors of the latter study actually

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<sup>95</sup> Buyx (2008) argues that even after all the effort that has gone into public health campaigns "*the health literacy of large parts of the population remains insufficient*".

<sup>96</sup> Tellingly, a significant numbers of respondents in this study did not realise that people with these diseases suffered considerable ill-health and pain.

concluded that most people “*do not have even a basic understanding of the nature and severity of the consequences of smoking*” (Ibid, p 354).<sup>97</sup>

The situation with regard to alcohol is even worse. A survey conducted by the British government found that although the majority of people knew that drinking alcohol caused liver damage, 85% did not realise that drinking increased the risk of breast cancer, 66% did not know alcohol increased the risk of bowel cancer and 59% did not know that alcohol can cause oral cancers (BBC News 2012). Other risky behaviours – and the diseases that they cause – are even less well understood. For example, a recent study found that only 2.5% of people could cite Human Papilloma Virus as a cause of cervical cancer even though about 90% of cervical cancer cases are caused by this virus (Marlow et al. 2007).

This generalised ignorance of the risks associated with certain behaviour has bemused a number of commentators. Richardson (2008) notes that he does not “*understand how the general population cannot get this message [about the risks associated with some common behaviours] because it is blazoned out from every pillar and post*”.<sup>98</sup>

Many of these same commentators also argue that the sheer availability of information makes people’s ignorance culpable. In this vein, Thornton (2009) argues

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<sup>97</sup> There is also a particular problem with the understanding of degree of risk. For example, one study has shown that smokers underestimate the death rate from lung cancer and overestimated survival duration and another study has demonstrated that a significant proportion of smokers underestimate the risks of stroke, heart disease and respiratory disease (Schoenbaum 1997). As I noted previously, this is, in some ways, more understandable because it is well known that the general populations’ understanding of statistical risk is poor.

<sup>98</sup> It is especially difficult to fathom how it is possible for the majority of citizens to fail to understand the risks of smoking and drinking alcohol given that it would seem to be hard to avoid learning about this information even if one was trying not to learn about the risks.

that “*extensive media publicity and health promotion campaigns have provided the public with information about how additive alcohol can be* [which means that] *ignorance of the dangers of alcohol is a less convincing plea in light of this publicity drive*”. However, before we jump to this conclusion we need to think about why so many people continue to remain ignorant about the risks that they take and whether the explanations that we uncover offer reasons to conclude that people’s ignorance is non-culpable.

One possible explanation for most people’s continued ignorance in the face of overwhelming information is that they lack the capacity to understand the information that is available. However, as I argued earlier in this chapter, although a certain group of people (e.g. those who have suffered some kind of brain damage) may not have sufficient mental capacity to understand information about risky health affecting behaviours there is no reason to think that this is true of most people. The only exception to the rule relates to the issue of people’s capacity to understand probability, but we know that people’s ignorance is not limited to a failure to understand degrees of risk and so this explanation does not explain why ignorance is so rife.

Another reason for the high levels of ignorance about risky behaviour could be that many people lack the linguistic skills to understand the information that is being provided. Many people living in developed countries are immigrants and many immigrants lack a sound grasp of the dominant language of their adopted country. As such, they may lack the ability to both search for and understanding the health information that is available. A significant number of adults – especially those in

social groups V – also receive such a poor education that they are entirely, or partially, illiterate.

However, information about many risky health affecting behaviours is now available in a whole array of different languages on many websites and many developed world governments provide translators who can help health care professionals to explain health information to patients. People who are illiterate, meanwhile, still have access to health care professionals who can explain the information to them verbally if need be. It is also worth bearing in mind that the people who took part in the studies quoted above were literate and could speak English. As such, this particular explanation cannot explain the scale of the ignorance that seems to exist either.

Yet another explanation for people's ignorance is that most people simply cannot be bothered to put much effort into finding out about the information that is available. People make a voluntary choice not to learn more about the risks they take because this would take too much time and energy. It is hard to prove that this is actually the case, but most people's level of understanding is close the level one would expect if they primarily accessed the type of information about risky behaviour which is made available via government advertising and warning labels placed on various products.<sup>99</sup> In other words, what happens in most cases is that people take note of this kind of

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<sup>99</sup> There is a limit to how much time and effort we can expect people to dedicate to such activities and this idea is captured by the concept of "reasonable expectations of effort". The point is that beyond a certain point spending more resources finding out about risks would appreciably reduce the amount of time available to get involved with other normatively valuable aspects of life and this is simply not a normatively reasonable demand. However, I would also argue that the amount of effort needed to find out about relevant information in the internet age is simply not sufficient to warrant claims to the effect that the degree of effort being demanded is unreasonable.

information but they do not seek to “top up” their knowledge by reading further about the risks online or by visiting their health care professional because doing so takes too much effort.<sup>100</sup>

We should also bear in mind that some people will deliberately avoid finding out about some aspect of a health affecting behaviour for reasons that are not connected to a failure of effort. Some might do so because they are scared of what they might find, whilst others might do so because they enjoy taking a risk that is of an unknown nature and quantity or because finding out about the risks associated with a given behaviour will ruin their enjoyment of the activity in question.

What, then, are we to make of all these explanations for continued ignorance in the face of overwhelming information? Should we conclude that those who proffer these “excuses” are not culpably ignorant? The answer depends on which “excuse” people are relying on. If people are ignorant because they choose to avoid finding out about the risks because this would reduce their pleasure, or because they could not be bothered to expend the energy to find out, or because they actually wanted to take an unknown risk, or because they were somewhat afraid of finding out about the risks then I think that their ignorance should be regarded as culpable.

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<sup>100</sup> Some people might claim that they are “too busy” to actually find out the information they need to find out about, but given that it takes no more than a few hours to read the relevant information online it is hard to believe that this is an acceptable explanation. Most people spend umpteen hours taking risks in their lives (perhaps as much as an hour a day if they smoke regularly, for example) and it is hard to believe that people cannot spend a few short hours finding out about what might happen if they continue engaging in their risky behaviour of choice.

On the other hand, if people are ignorant because they lack the mental capacity to understand information, or because information is not available in a language that they can understand, or because they are illiterate, or because their fear of the risks was literally overwhelming, I think we should regard their ignorance as (largely) non-culpable.

Thus, because I think that most people are ignorant because they cannot be bothered to find out about the risks that they take, we should conclude that ignorance – at least when relevant information is sufficiently accessible and sufficiently comprehensible – is culpable.<sup>101</sup>

#### **5.3.4 The epistemological condition: conclusion**

In conclusion, the epistemological condition does obtain in most cases and most people are, to a significant degree, morally responsible for their risky health affecting behaviours. This is because there is enough relevant health information available to people in easily accessible and readily comprehensible forms and the reasons why most people continue to remain ignorant are culpable reasons. There are exceptions to the rule and I accept that most people's degree of moral responsibility is partially

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<sup>101</sup> I would like to add at this point that people need to be given a reasonable amount of time to learn about new discoveries before their continued ignorance is deemed culpable. The problem is that it can take years from the point that scientists and epidemiologist make discoveries about the links between behaviours and diseases to the point where we can safely say that this information has been well publicised. Quite how much "lag time" is required before we can conclude that people's continued ignorance is culpable is not clear, but I think that at least a few years must pass by from the point at which a serious public health campaign begins before we can start making these claims.

diminished by the fact that certain information is not very easy to find. However, I am confident in claiming that, from the perspective of the epistemological condition, the vast majority of people are significantly morally responsible for their risky health affecting choices.

#### **5.4 Moral responsibility: general conclusion**

In this chapter I have argued that we have good reason to think that a majority of people are significantly morally responsible for their risky health affecting behaviours. This is because there is good reason to think that the mental capacity, freedom and epistemological conditions do obtain in the real world. In other words, people have sufficient mental capacity, sufficient freedom and sufficient access to information to be morally responsible for their risky behaviour.

Having said as much, I have conceded that certain groups of people (e.g. children) are not morally responsible for their risky health affecting choices in any way and that other people (e.g. people who have only limited access to certain health information) are only partially morally responsible and I have also accepted that a whole range of different factors will sometimes club together to significantly reduce some people's degree of moral responsibility. Nevertheless, this is very much the exception to the rule and most people should be regarded as substantively morally responsible for their risky behaviours.

However, before moving onto the next chapter I would like to make one final point. This relates to the fact that people's degree of moral responsibility is likely to be



much higher in the case of risks such as unprotected sexual intercourse, occupational hazards, sunbathing and sports related injuries than it is in the case of risks such as smoking, drinking and the consumption of recreational drugs. This is because there are far more “responsibility diminishing” factors at play in the case of the latter behaviours than the former behaviours. This is important because the surveys in chapter 3 suggest that most people think that risky behaviours like smoking, drinking and consuming drugs should be penalised more than other kinds of risky behaviours.

There may be many reasons why it is more legitimate to penalise smokers rather than sunbathers even though people are less morally responsible for the former behaviour. However, the fact that smokers (and other users of addictive drugs) are generally less morally responsible than people who engage in other kinds of risky behaviours does give us some reason to think that these people should have to pay *fewer* costs than people who take other kinds of risks. Indeed, I will argue in the next few chapters that cost bearing policies should try to ensure that people bear costs in proportion to their degree of moral responsibility and this ultimately means that people who smoke, drink and take drugs may well have to pay fewer relative costs than people who sunbathe, have unprotected sexual intercourse and take part in extreme sports – although whether we draw this conclusion depends on the normative arguments that underpin our cost bearing claims.

## Chapter 6

### Consequential Responsibility: Should People Bear Costs?

*“What did you do this past summer? “Oh” said the grasshopper, I kept myself busy by singing all day long and all night, too”. “Well then”, remarked the ants, as they laughed and shut their storehouse, “since you kept yourself busy by singing all summer, you can do the same by dancing all winter.”*

– Aesop

#### 6.0 Introduction: normative defences of cost bearing

Over the course of the last few chapters I have argued that people are causally responsible for their ill-health and morally responsible for their decisions to engage in risky health affecting behaviours. In this chapter, I will try to determine whether people who are causally and/or morally responsible should bear some sort of health cost. In order to do this I will analyse five different normative arguments which converge together in the sense that they can all be used to defend the claim that people who engage in certain “core” types of risky health affecting behaviours should bear some of the costs of their choices. Some of these arguments also defend cost bearing in “non-core” cases and I will highlight this divergence in the five arguments at the end of the chapter.

During my analysis I will claim that one of these five arguments (i.e. the luck egalitarian argument) is more compelling than the others and I will claim that this argument provides us with a sound basis for making people consequentially

responsible for their risky health affecting choices. The other arguments that I will explore also have some merit, but I will suggest that they face a number of problems which are difficult, though perhaps not impossible, to overcome.

### **6.1 Bearing costs: an overview of the five normative arguments**

There are many different possible ways of defending the claim that people who are morally responsible for a health affecting behaviour should bear some kind of health cost. However, I will only discuss what I will call the “moralistic desert”, “expected consequences”, “rights-harm”, “luck egalitarian” and “utilitarian” arguments in this thesis. I will explain why I will focus on these arguments in a moment but, before I do so, I will very briefly state the core claims that underpin each of these arguments.

The first argument that I will explore will be an argument based on the concept of desert. As we shall see, desert, like responsibility, can mean many different things to many different people, but, in this thesis, I will rely on what I will call a “moralistic” version of the desert-based family of arguments.<sup>102</sup> In particular, I will argue that cost bearing in relation to risky health affecting behaviour can be defended on the basis of the moralistic desert argument as long as the following claims are sound: that there is something *intrinsically* immoral about certain kinds of risky health affecting behaviours and that people who are morally responsible for engaging in these kinds of

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<sup>102</sup> Desert need not be a moralised concept in the way that I use it in this thesis. For example, it may be conceptualised in a prudential rather than a moral form. Thus it could be argued that people deserve to bear costs because they have been imprudent rather than because they have behaved in an intrinsically immoral fashion.

behaviours should bear some health costs as a form of “punishment” or “sanction” or “denial of benefit”.

The second argument that I will scrutinize is the expected consequences argument. This argument – which might also be dubbed the “autonomy” argument – defends cost bearing on the basis of two primary premises. The first premise is that autonomy is an extremely important value and the second premise is that the only way that autonomy can be properly valued is if people who make autonomous choices are made to bear the expected consequences of these choices. Applied to risky health affecting behaviours the basic claim will be that people ought to bear some of the costs of their risky health affecting behaviour because bearing some of these costs is an expected consequence of their risky choices.

The third argument that I will analyse is the rights-harm argument. This argument is based on the claim that citizens have a limited and forfeitable positive right to healthcare and that they also have a duty to ensure that other people’s positive rights to healthcare are upheld. In practical terms this means that people who are morally responsible for taking risks with their health and subsequently fall ill must bear some of the costs of their choices in situations of resource scarcity. This is because, if they don’t bear the costs of their risky choices in these kinds of situations, they will decrease the amount of resources available to people who are not causally and morally responsible for their ill-health and doing this will harm these people by violating their positive right to healthcare.

The fourth argument that I will investigate is the luck egalitarian argument. This argument states that people who are morally responsible should be made to bear the costs of their health affecting choices because justice requires that public resources (which include health care resources) should be distributed to people suffering from sheer bad luck rather than from the unfortunate effects of their own choices. The claim, in effect, is that considerations of fairness entail that people who are morally responsible for taking risks with their health should be treated differently from people who are not morally responsible for their ill-health. More specifically, fairness requires that only the latter group should be compensated by society.

The last argument that I will analyse is the utilitarian argument. Utilitarians, I will suggest, can defend cost bearing on the basis that requiring people who take risks with their health to bear costs will incentivise people to modify their risky health affecting behaviour. Obviously, making people bear costs will reduce utility in some ways, but the utilitarian may be able to claim that the incentive effects of implementing cost bearing policies outweigh the harm caused and, as a consequence, net utility will increase if these policies are put in place.<sup>103</sup>

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<sup>103</sup> As I noted in the first chapter, the utilitarian argument differs from all the other normative arguments that I will analyse in this chapter because moral responsibility is not a necessary condition for consequential responsibility according to this account. In other words, the utilitarian could defend cost bearing policies even if people are not morally responsible for taking risks with their health. The reason why this is true is because incentives can work in situations where people are only causally responsible for their risky health affecting behaviours. For example, it is possible to incentivise a young child not to play with fire even though a young child is not morally responsible for deciding which risks to take in life.

I will limit my discussion in this chapter to these five arguments for the following reasons. The moralistic-desert argument is, I think, the argument that underpins most people's beliefs that some patients should bear some of the costs of some of their risky health affecting choices. As such, it is probably the most popular of all the normative arguments that exist to defend cost bearing and deserves a proper hearing for this reason. The expected consequences argument, meanwhile, seems like a potentially promising argument because there is an overlapping consensus in liberal democratic cultures that autonomy is very valuable. Thus, if the argument can be shown to work it is likely to attract many supporters.

The rights-harm argument is worth exploring because the concepts of "rights" and "duties" increasingly pervades the discourse of policy makers interested in health care policies. As such, this argument is likely to appeal to wide variety of different stakeholders if it can be shown to be sound. The luck egalitarian argument is also worth discussing partly because it has already been mooted by many philosophers as a theory of justice that could be used to defend cost bearing in relation to health and also because this argument is very compelling (Segall 2010). Finally, the utilitarian argument is worth analysing because utilitarianism is still regarded as the dominant normative approach from the point of view of many health care policy makers and this approach has much to be said for it – especially when it is combined with the principle of "moral responsibility" to form a hybrid or pluralistic argument.

These arguments are not exhaustive and it is entirely possible that other normative arguments – such as a solidarity based argument or a libertarian argument – could provide an even more robust defence of cost bearing in relation to risky health

affecting behaviours (Brown 2009). However, I do not have space in this thesis to discuss every possible argument that could be deployed to defend cost bearing and so I will limit myself to the five arguments that I have briefly outlined above.

## 6.2 Desert

Health care professionals, policy makers and lay people regularly claim that patients who are responsible for their ill-health *deserve* their ill health. Similarly, patients who are said to deserve their ill-health are also sometimes said to deserve to bear the costs of their health affecting behaviour. Quite what is meant by these claims is not easy to decipher because desert – like responsibility – is a slippery and complex concept which often signifies different things to different people in different situations.<sup>104</sup> For example, the following claims are all intelligible and widely held but they also reflect very different usages of the concept of desert: a heroic person deserves a reward for his valour; an evil man deserves to be unhappy; a diligent student deserves high grades for his efforts; a generous man deserves good luck because of his munificence and a rapist deserves to be punished for harming others.<sup>105</sup>

However, I think that when most people make desert claims in relation to risky behaviour they are relying on what I call a moralistic desert claim. In particular, they are adopting the idea that people should bear the cost of at least some of their risky

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<sup>104</sup> The sheer variety of desert claims raises the possibility that there may be no single concept of desert although we use the term desert as if it signifies one concept.

<sup>105</sup> When we consider what Feinberg (1970) calls the “desert basis” we might say that X deserves Y either because X has performed some deserving act (e.g. an act of heroism) or because something bad has happened to them (e.g. suffering) or because one or more of X’s characteristics (e.g. generosity of spirit) is itself deserving.

health affecting behaviours because some of these behaviours are intrinsically immoral. By “intrinsically immoral” I mean that the behaviours are inherently wrong or inherently bad for reasons that are independent of consequentialist calculations.<sup>106</sup> I also think that people who adopt this approach commit themselves to the further claim that people who choose to engage in such behaviours deserve to be punished or sanctioned or denied a benefit as a consequence.<sup>107</sup>

I am not alone in believing this. Cohen and Benjamin (1991) argue that support for policies which deny liver transplants to alcoholics is explained by the fact that many physicians believe that heavy drinking is intrinsically “*morally wrong*” and that such behaviour ought to be sanctioned. Likewise, Wikler (1978) argues that some kind of moralistic claim underpins many people’s beliefs that certain risky health affecting behaviour is immoral and should be penalised in some way.<sup>108</sup>

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<sup>106</sup> Consequentialists would regard risky health affecting behaviours as *instrumentally* rather than *intrinsically* immoral. Utilitarians, for example, would argue that risky health affecting behaviours are only immoral if they diminish net utility and would be happy to re-describe these behaviours as moral if they, in fact, increased net utility.

<sup>107</sup> In this thesis I will not distinguish between punishment, sanction and denial of benefits. Anecdotal evidence suggests that some people do construe cost bearing as a form of punishment. Indeed, the language of punishment is sometimes used when health care professionals discuss these issues. However, other people eschew the language of punishment and prefer to talk of sanctioning or denying people a benefit for engaging in risky behaviours.

<sup>108</sup> Other desert-based approaches to defending cost bearing are possible, but I will not explore them here. Denier (2005), for example, argues that costs and benefits could be denied or awarded on the basis of “energy expended” – i.e. on the basis of effort.



### 6.2.1. Evidence of wolves in sheep's clothing

Some people openly embrace the claim that a wide range of risky health affecting behaviours are intrinsically immoral and that people who engage in such behaviours should be punished or sanctioned or denied a benefit by being forced to bear costs. Newspapers are full of claims that “wanton” alcoholics should not receive liver transplants and that “reckless” drug addicts should not receive free health care. Moreover, as we have seen, the academic literature is replete with physicians and others openly declaring their adherence to these beliefs.<sup>109</sup>

Evidence gleaned from a number of surveys also suggest that many patients, health care professionals and members of the lay-public believe that some risky health affecting behaviours are vicious or wrong and that people deserve to bear some cost precisely for this reason. For example, a number of recent studies exploring people's beliefs about obesity demonstrate that many people openly describe obese patients as “*lazy*”, “*gluttonous*”, “*immoral*” or “*undisciplined*” and that they “*get what they deserve*” when then fall ill (Kelly et al 2010).<sup>110</sup> Yoder (2002) also notes that there is growing evidence to suggest that people tend to “*attribute moral qualities to people based on their health*”.<sup>111</sup> People who engage in certain kinds of risky behaviour also

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<sup>109</sup> Knowles (1977) overtly adopts a moralistic position and seems more than happy to use the traditional language of vice to describe many risky health affecting behaviours.

<sup>110</sup> It might also be remembered that in one of the studies that I analysed in chapter 3 many respondents claimed that people who were responsible for taking risks with their ill-health were “*less deserving*” than patients who did not take such risks (Neuberger et al 1998).

<sup>111</sup> For example, people who are thin and look fit tend to have positive attributes such as the ability to work hard, delay gratification and control impulses to them, whilst people who are overweight and look unfit tend to have negative attributes such as laziness, indolence and lack of self control attributed to them (Brownell 1991).

regularly report that they suffer prejudice because other people make moralistic judgements about their choices of behaviour even when these behaviours are primarily or entirely self-harming.<sup>112</sup>

However, although a number of people openly declare their allegiance to moralistic desert claims, many more seem to harbour such beliefs without openly stating that they do. Two different kinds of evidence suggest that this is the case and I will briefly discuss this evidence here before moving on to analyse the moralistic desert argument in more detail.

The first piece of evidence is the manner in which some people use distinctly moralistic language when describing risky health affecting behaviour whilst denying that they are defending cost bearing policies on the basis of some kind of “intrinsic” immorality judgment. Many people who ostensibly claim that they do not adhere to an intrinsic immorality approach to cost bearing argue that “sloth”, “gluttony” and “sexual promiscuity” are the causes of various risky health affecting behaviours. In doing so they correctly identify the fact that lack of exercise, over-eating and sexual

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<sup>112</sup> The following statement neatly demonstrates how judgmental some people can be when they encounter people who are obese: “*one morning I gained 150lb, and my whole life changed. My husband looked at me differently, my kids were embarrassed, friends felt sorry for me, and strangers were shamelessly disgusted by my presence. The pleasures of shopping, family outings and going to parties turned into wrenchingly painful experiences. In truth, I became depressed by just the thought of running the most basic errands; a trip to the grocery store or the video shop was enough to put me in a bad mood. But mostly, I became angry. Angry because what I experienced in the week that I wore a ‘fat suit’—designed to make me look like a 250-plus-lb woman—was that our society not only hates fat people, it feels entitled to participate in a prejudice that at many levels parallels racism and religious bigotry. And in a country that prides itself on being sensitive to the handicapped and the homeless, the obese continue to be the target of cultural abuse*” (Lampert 1993).

promiscuity (at least when coupled with unsafe sexual practices) are causes of diseases, but their eschewing of technical terms in favour of morally loaded terms rather gives the game away (Wikler 1978).

This phenomenon is most obvious in relation to sexual promiscuity. Many argue that people who are promiscuous should bear the costs of their promiscuity – i.e. the costs associated with sexually transmitted diseases. However, this claim seems to rest on a very selective reading of the data on promiscuity. It is certainly true that people who are more sexually promiscuous are more likely to suffer from sexually transmitted diseases, but this is not because of their promiscuity. It is because a substantial proportion of people who are promiscuous do not practise safe sex. In other words, this sub-group essentially skew the data by making it look like promiscuity is the primary cause of the increase in sexually transmitted diseases when the real problem is lack of safe sexual practice. Promiscuity itself is, to a large extent, a confounding variable.

This is important because it means that people who are concerned with holding people responsible for their health-affecting actions should be unconcerned with promiscuity. Instead, they should be concerned with people who practice unsafe sex. Yet, crucially, the emphasis of many people's arguments invariably still rests on the promiscuous or, to use Knowles' (1977) terminology, the "*sexually intemperate*" rather than on people who practise unsafe sex. One might argue that this simply reflects ignorance about the difference between unprotected and protected sexual intercourse, but this seems increasingly unlikely given the widespread understanding that it is unprotected sexual intercourse which creates risk. The more likely explanation is that promiscuity is still

regarded as an intrinsically immoral behaviour by many people and it is because of this that they defend the claim that people who develop sexually transmitted infections should bear the costs of their choices.

The other source of evidence is the selective way in which many people pick from the list of possible health-affecting behaviours when they defend cost bearing policies on the basis of “responsibility for health” judgements. Of the wide range of different behaviours that cause disease, lay and professional commentators alike almost invariably limit their discussion to those behaviours that are traditionally deemed “sins” rather than to more socially acceptable (but equally risky) behaviours (Wikler 1978; Harris 1995). Even in the academic literature a great deal of the research on the topic of responsibility for health concentrates on people who have abused addictive substances (e.g. tobacco, alcohol, recreational drugs), people who are sexually promiscuous and, to a lesser extent, people who consume too much food and are overweight or obese. Very little mention, if any, is made of pregnant women, athletes, recreational skiers, firemen, policemen or healthcare professionals.

If one openly defends an intrinsic immorality position, then concentrating one’s fire on a limited number of risky health affecting behaviours makes sense, but for those who proclaim that they do not base cost bearing judgments on the basis of the intrinsic immorality of certain risky behaviours this focus of attention on traditionally “sinful” behaviour is, again, rather telling. Indeed, Wikler (2002) argues that “*the coincidence of two lists, that of lifestyles deemed burdensomely expensive and that of lifestyles deemed sinful... suggests a different agenda from the stated one*”.

These two sources of evidence do not prove conclusively that some people are secretly harbouring beliefs about the intrinsic immorality of certain risky health affecting behaviours. In particular, the second kind of evidence that I discussed above could be explained on the basis that people are making their judgments on the basis of utilitarian arguments. Nonetheless, the first kind of evidence in combination with the second kind of evidence is very suggestive and I think that it is reasonable to claim, on the basis of this evidence, that the “intrinsic immorality” position may be the most popular defence of cost bearing of all – at least amongst the lay public.

### **6.2.2 The moralistic desert argument in detail**

I mentioned earlier that the moralistic desert argument depends on the claim that some risky health affecting behaviours are intrinsically immoral and that these behaviours are intrinsically immoral in such a way that people who engage in them deserve to bear a cost as a form of punishment or sanction or as a denial of benefit. If we spell out the whole desert argument it runs as follows:

1. All risky health affecting behaviours involve taking risks which can cause harm to oneself and some of these behaviours involve taking risks which can cause harm to other people.
2. Behaviours which risk harming other people or risk harming oneself are intrinsically immoral (i.e. wrong or bad) unless they are done for good reason.
3. Some risky health affecting behaviours which harm other people and some which harm the self are not done for good reason.
4. *Therefore*, some risky health affecting behaviours are intrinsically immoral

5. People who engage in intrinsically immoral risky health affecting behaviours deserve to be punished or sanctioned or be denied a benefit by the state for retributive reasons.
6. Forcing people to bear some of the health costs of their choices is one legitimate method of punishing or sanctioning or denying a benefit to people who have engaged in risky health affecting choices which are intrinsically immoral.
7. *Therefore* people who engage in some risky health affecting behaviours deserve to be penalised and the penalty may take the form of cost bearing.

The first premise of the argument is self-evident and I will simply take it for granted that all risky health affecting behaviours can cause harm to oneself and that some can also cause harm to other people. The other premises of the argument are much more controversial and I will now discuss these propositions in the following sub-sections.

#### **6.2.2.1 The intrinsic immorality of harm to self and harm to others**

The claim that actions which harm other people are intrinsically immoral is widely accepted by many philosophers and lay people alike. At least some of these other-harming behaviours can also be classified as “risky health affecting behaviours”.<sup>113</sup> However, most risky health affecting behaviours do not cause direct harm to other people.<sup>114</sup> This means that we cannot rely on claims about the intrinsic immorality of other harming behaviour if we wish to argue that most people who take risks with

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<sup>113</sup> Assault and rape fall neatly into both categories.

<sup>114</sup> Eating too much saturated fat, sunbathing excessively and drinking alcohol are not activities that harm other people in any obvious way.

their health ought to bear the costs of their choices.<sup>115</sup> Instead, we must rely on the much more controversial claim that self-harming behaviours (which are done for no good reasons) are intrinsically immoral.

Traditionally, three arguments have been proffered to defend the idea that at least some self harming behaviour can be intrinsically immoral. The first argument is religious in nature, the second argument is based on Kant's theory of morality and the third argument ultimately derives from Aristotle's theory of virtue. I will now discuss the Kantian and Aristotelian arguments in more detail, but I will ignore the religious argument because, even if many people accept the validity of this argument, it is not possible to underwrite public policies in secular countries like the UK on the basis of an argument that relies on theistic premises.<sup>116</sup>

#### **6.2.2.1.1 The Kantian argument**

In the *Metaphysics of Morals*, Kant (1998) discusses a number of different risky health affecting behaviours and he classifies many of these behaviours as intrinsically immoral even though they only cause harm to oneself. Kant does not provide an exhaustive list of these behaviours in his work but he does mention suicide, gluttony

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<sup>115</sup> For the purposes of this thesis I will ignore the complication that some risky health affecting behaviours can harm other people in certain situations. For example, I will ignore the fact that smoking in the presence of other people can cause harm (i.e. the phenomenon of passive smoking) and the fact that people who drink too much alcohol or consume certain types of recreational drugs are more likely to harm other people whilst driving under the influence of these drugs.

<sup>116</sup> The religious argument comes in many forms but the key underlying claim is that self harm is intrinsically immoral because people do not have the right to harm *any* of God's creations (including oneself) without authority from God himself. Indeed, this rationale provides one the key reason why suicide is frowned upon by many of the world's major religions.

and drunkenness as classic examples of self harming behaviours and there does not seem to be any reason why his arguments could not be extended to include other risky health behaviours like “sloth”, smoking and excessive sunbathing. Indeed, given Kant’s arguments it seems that we are committed to extending the list he constructs to cover a whole range of other risky health affecting behaviours.

At first glance, the rationale provided by Kant as to why certain self harming behaviours should be classified as intrinsically immoral seems to depend on the behaviour in question. Kant (1996) argues that gluttony, or as he puts it: “*self stupefaction [by the] excessive use of food or drink*”, is intrinsically immoral because it is such an unnatural use of one’s attributes that it represents a “*violation of one’s duty to himself*”. His argument against suicide, meanwhile, is based on the claim that “*to destroy the subject of morality in his own person is tantamount to obliterating from the world, as far as he can, the very existence of morality itself; but morality is, nevertheless, an end in itself. Accordingly, to dispose of oneself as a mere means to some end of one’s own liking is to degrade the humanity in one’s own person*”.

However, though Kant seems to offer different reasons why engaging in certain kinds of risky behaviour is immoral it has been suggested that Kant’s core argument about the immorality of self-harming behaviour boils down to two claims. Firstly, harming oneself often involves using one’s self or one’s humanity as a mere means (Denis 2010). Secondly, harming oneself in some situations involves the destruction of the faculties on which the exercise of our freedom – and thus our capacity to be moral – depends (Korsgaard 1996).



The latter claim seems to be compelling. Kant's argument in this case is that we have a duty to preserve both the physical and mental faculties upon which we depend to act freely and rationally – i.e. the faculties upon which we depend in order to act in accordance with the moral law. Risky health affecting behaviours tend to damage or destroy these faculties. Self harming behaviours can cause temporary or permanent damage either to our physical bodies or to our brains/minds and in some cases they can kill us. Those self-harming behaviours that run the risk of killing us are immoral because they run the risk of permanently destroying the faculties upon which our exercise of freedom depends, whilst those self harming behaviours which run the risk of damaging us are immoral because they can either temporarily (e.g. during a gluttonous stupor) or permanently (e.g. after a stroke) hamper those same capacities (Guyer 2006).

Kant does not argue that *all* risky health affecting behaviours are intrinsically immoral. He explicitly argues that it is permissible in certain situations to sacrifice one's life in order to save one's fellow countrymen and his reason for making this claim is that such behaviour, though it involves the potential destruction of one's capacities, will protect other people's capacities to act freely and rationally (Korsgaard 1996). Likewise, I think Kant would accept that women who choose to have unprotected sex in order to have children, though they take risks in the process, cannot be regarded as treating themselves or their humanity as a mere means. Indeed, a wider claim can be made here, namely that Kant would allow – and even encourage – people to take risks whenever their goal was to protect other people's capacities to be free and, hence, moral.

In summary, Kant seems to believe that people who take risks with their health (e.g. by drinking too much alcohol) for no good reason should be regarded as acting in an intrinsically immoral way and that we all have perfect duties to avoid taking risks without good reason. However, he also believed that people who take risks with their health for good reasons (i.e. in order to protect other people's capacities to be free, rational and moral) should not be regarded in this light and should, in fact, be regarded in a good moral light. What is not as clear is what Kant would make of what I described in chapter 4 as "everyday risks".<sup>117</sup>

Some everyday risks are necessary risks and Kant would presumably accept that there was nothing impermissible about taking such risks. However, some everyday risks are not strictly necessary; they could be avoided but only at some practical cost. For example, if driving in a car is more dangerous than taking public transport then we can say that taking the risk of driving a car is not necessary as long as public transport is available. This is true even if it will inconvenience us and reduce our ability to do that which we wish to do.

I am not entirely sure how a Kantian would deal with this problem. It is possible that Kantians would allow some degree of leeway in relation to everyday risks, but it is not entirely clear on what basis an exception could have been made. Kant certainly believed that we had duties to develop our talents and it may be that if taking the least risky option each day meant that the development of our talents would be adversely

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<sup>117</sup> Kant (1996) was not opposed to all forms of intoxication. He seems to have believed that the consumption of a small amount of wine might promote our faculties in certain contexts – e.g. at a dinner party. However, he would certainly have opposed the idea that getting seriously intoxicated was acceptable and given our modern understanding of the dangers of addiction Kant might also have taken a harsher line with regard to the consumption of any amount of alcohol.

affected this would provide us with sufficient reason to take greater risks. However, Kant also believed that the duty to develop our talents is an imperfect duty whilst our duty not to destroy or damage our bodily and mental faculties is a perfect duty. As such, it does not seem likely that the duty to perfect our talents would override the duty to take the least risky option where everyday risks are concerned.

Not everyone will be convinced by the Kantian claim that certain risky health affecting behaviours are intrinsically immoral. Consequentialists, will deny that the right way to assess the moral permissibility of an action is to address whether it involves treating people as mere means or whether it destroys or damages the faculties that we rely upon in order to be free, rational and moral.

Even people who are sympathetic to Kant's general arguments and accept that behaviours which involve treating *other people* as mere means is intrinsically immoral deny that Kant's arguments can be applied in relation to behaviours that harm the self. For example, some Kantian scholars have argued that it is conceptually confused to suggest that we can have duties to ourselves or that we can violate rights that we owe to ourselves or that we can create binding obligations by making promises to ourselves (Denis 2010). Such a duty seems to make the person who will be constrained the same person that as the person who is doing the constraining and this is problematic because it seems that we could always escape from such obligations by releasing ourselves from them (Wood 2007). It is not clear in what sense it is possible for us to be *bound* by a duty which we can seemingly release ourselves from at will.

I will not respond to the consequentialist critique of Kant's arguments here for this is too large and complex a counterargument for me to deal with properly in this thesis, but I will respond to the other argument that Kant was wrong to think that we can have duties to ourselves. As it happens, Kant was well aware that the idea of a duty to oneself might seem incoherent and he opens his exposition of these duties by admitting that the whole notion of a binding duty to oneself sounds implausible because one could release oneself from such a duty with ease (Kant 1996). However, he counters these objections on the basis that human beings are part animal and part rational – or part “sensible” and part “intelligible” – and that the latter aspects of our humanity can impose binding obligations on the former aspects (Guyer 2006). To put it another way, the author of an obligation to ourselves is not the same person as the subject who is obliged and so we cannot release ourselves from the grip of self-imposed duties at will.

If I do not have space to explore these Kantian arguments in any further depth here, but for those who are convinced that Kant was right to claim that certain kinds of self-harming behaviour are intrinsically immoral, a means of defending cost-bearing on the basis of desert is certainly opened up by Kant's arguments. Admittedly, I do not think that many lay-people, health care professionals or policy makers ground their cost bearing claims on the basis of this kind of argument. Moreover, Kant's arguments rest on claims (e.g. the claim about sensible and intelligible aspects of our humanity) which are dubious and difficult to prove. However, the Kantian position is not without plausibility and it does have the advantage that it neatly divides different risky health affecting behaviours – with the possible exception of “everyday risks” – in a way which will appeal to the intuitions of most people.

#### 6.2.2.1.2 The Aristotelian (virtue) argument

The other, non-religious, argument that seeks to explain why causing harm to self is intrinsically immoral is derived from Aristotle's (1984) theory of virtue. From the Aristotelian point of view any behaviour (which is based on stable character trait) is "intrinsically immoral" or, to use the actual Aristotelian language, "vicious", if it inhibits human flourishing (*eudemonia*). Consequently, if we can demonstrate that certain kinds of risky health affecting behaviours inhibit human flourishing it will be possible to argue that these behaviours are vicious or bad in an intrinsically immoral sense.<sup>118</sup>

It may be argued that engaging in *any* risky behaviour is vicious. This is because health and existence is necessary for human flourishing and risky behaviours may damage people's health or kill people prematurely. However, although this "all risks" approach is *prima facie* plausible and although it has the advantage that most people will agree that ill-health – and death – inhibit human flourishing the argument also suffers from a number of problems.

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<sup>118</sup> Some people will agree with the general thrust of the virtue-based argument but feel uneasy about the use of the language of vice to describe people who take certain risks with their health. Indeed, some people will feel more comfortable saying that the act of smoking has little moral worth (or some kind of "negative" moral worth) than saying that the act of smoking is vicious. Moreover, using the language of moral worth in this way – and eschewing any direct reference to virtue and vice – has the advantage that we can still make moral claims about the kinds of risks people take but we are not so reliant on language which is morally loaded. However, I will stick with Aristotle's language of virtue and vice in this chapter because this language is more in keeping with the way many people actually voice their values about those who take certain risks with their health. Knowles (1977), for example, is unequivocal about this and he is far from being alone in this matter. That said, there is no necessity in this and anyone who wishes to substitute the language of virtue and vice with the language of moral worth in the following section can certainly do so.

The most serious issue is simply that the all risks approach is committed to the claim that there is something intrinsically immoral about risky behaviour even when the behaviour is carried out for ostensibly virtuous ends. It may be possible to argue that the viciousness or badness of such an action can be “overcome” if the action is done for reasons that significantly contribute to the flourishing of others. However, it makes little conceptual sense to claim that there is *anything* vicious or bad about an act which causes harm to oneself but which is carried out for good reasons – such as an act carried out for the sole purpose of enabling other people to survive and flourish. In fact, an altruistic act that involves taking a risk of causing harm to oneself furnishes us with a reason to claim that the act is more, not less, virtuous.

This objection suggests that an alternative to the “all risks” approach is needed. But the only alternative approach that might be viable would be an approach that would make use of a richer account of flourishing and a “thicker” conception of the good life. For example, it could be argued that people are only able to flourish and live a good life if they possess and regularly exhibit the following characteristics: caution, prudence, moderation, responsibility, determination, self control, sobriety, temperance, frugality, self restraint and moral courage.

On the basis of these specific claims it would be possible to argue that people who take risks with their own ill-health because they are impatient or reckless or cowardly etc. are vicious or bad because they behave in ways which damage human flourishing. For example, smokers who smoke because they cannot sublimate their desire for a cigarette could be deemed vicious for they lack the self control necessary for human flourishing and people who are obese because they lack self-restraint may be deemed

vicious because they are too weak willed to flourish. Similarly, people who sky dive or ski or scuba dive in order to experience the thrills of risk taking could be regarded as “vicious” because they are imprudent and reckless.<sup>119</sup> People who take risks with their health in order to protect other people, on the other hand, could be said to contribute to human flourishing and thus their risky actions could be deemed entirely virtuous or good.

As for people who take everyday risks it is not entirely clear what might be said of them. They can hardly be said to be reckless or imprudent just because they take such risks, but it is not clear that the rationale for taking everyday risks enables people to flourish either. This may incline people to think that the taking of everyday risks is, in some sense, a morally neutral activity. However, a good case can be made that human beings cannot properly flourish unless they can perform basic day to day activities without worrying too much about reducing day to day risks to a minimum. As such, it is reasonable to argue that the taking of everyday risks contributes, to a small extent, to human flourishing and should be regarded as morally permissible from the perspective of the particular virtue account that I have just outlined.

This narrower approach avoids the *reductio ad absurdum* associated with the claim that all risk taking activities are *prima facie* vicious. Moreover, the particular version of the narrow approach that I have outlined fits rather well with many people’s intuitions about which kinds of risky behaviours – and which kinds of reasons for engaging in risky behaviours – are morally acceptable and which are not. It also fits well with most people’s intuitive beliefs that pregnant women and firemen should not

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<sup>119</sup> This is a particularly good example of where the language of moral worth seems more appropriate than the language of vice.

bear costs, but that people who smoke and people who engage in risky sports should do so. Indeed, I think that it is precisely this kind of account that underpins most (non-religious) people's reasons for defending cost bearing in relation to risky health affecting choices. In other words, it is because people think that certain behaviours damage human flourishing that they deem these behaviours to be "vicious" and believe that people who engage in them should be penalised in some way.

However, though this narrower approach has these advantages over the "all risks" approach, they are bought at a relatively heavy price. The main problem is that the narrower approach depends on a quite a selective (and rather anti-hedonistic) reading of what it means for a human being to flourish. In other words, it depends on a very specific conception of the good and a highly circumscribed understanding of virtues and vices. As I have just noted, many people do seem to believe that individuals who cannot sublimate their desires, or who take risks with their health for frivolous reasons, or who consume so many recreational drugs that they are unable to function – and so on – fail to flourish. However, there is a great plurality of views about what it means to live a good life and many reasonable people disagree about which behaviours (and which reasons for acting) really enable people to flourish (Cohen and Benjamin 1991).<sup>120</sup>

Some people believe that living a hedonistic and care free life enables people to flourish in a way that a life of careful prudence and risk avoidance does not. In fact, they would probably argue that people who are always careful and restrained and prudent fail to properly appreciate a key element of what makes life worth living,

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<sup>120</sup> Daniels (2008) argues that risks that may seem to be entirely avoidable and utterly wrong from some people's perspective may be part of other people's conception of what makes life worth living.



namely the joy of taking risks and the sense of fulfilment that human beings can experience when they learn to overcome their fears. Furthermore, some people will regard risks taken in the name of ambition or pride or adventure (e.g. the reasons why some astronauts, mountaineers, deep sea divers and test pilots take the risks that they take) as inherently vicious in nature, but others will argue that ambition and pride contribute to human flourishing and that risks taken for these reasons are to be commended.

Others will argue that the kind of person who possesses the basket of character traits that I have described earlier on (i.e. self control, sobriety etc.) will stymie the development of other character traits (e.g. courage and curiosity) which are widely regarded as virtues even by those who defend the idea that a life of careful prudence is essential for human flourishing. Curiosity and courage often require us to take risks with our health and if we are unwilling to take risks for these reasons our capacity to develop and maintain our curiosity and courage will shrivel.

The claim that a life full of “frivolous” or “ambition driven” risk taking contributes more to human flourishing than a life of moderation and sobriety is not easy to prove. However, there is no *prima facie* reason to think that such a life does not contribute to human flourishing and no reason to think that the burden of proof must lie on those who believe that virtue lies in a high-octane existence rather than those who defend a more sedate conception of human flourishing. Indeed, there is some reason to believe that conceptions of the good (including conceptions of virtue, vice and human flourishing) *should* vary from person to person – at least to an extent. This is because human beings are very diverse and – quite apart from the fact there is some virtue in

diversity itself – it is possible that people who are very different can only flourish if they live very different lives.

As with the Kantian arguments that I discussed above, I do not intend to explore the merits and demerits of these virtue arguments in any more depth here. However, I will reiterate at this point that for those who believe that it is possible to define the good life in such a way that only certain kinds of risk taking behaviours (and only certain reasons for taking risks) contribute to human flourishing the first step in the moralistic desert defence of cost-bearing will have been established. This is because, if this account is true, it will prove possible to argue that certain kinds of self-harming behaviour are intrinsically immoral. I will also reiterate that this approach is not implausible and I think it explains many people's intuitions about who should, and who should not, bear costs when they engage in risky health affecting behaviour. Having said as much, there are substantial problems with the narrow and the "all risks" versions of the virtue based argument and I am not convinced that these problems can be overcome.

#### **6.2.2.2 Punishment, sanctions and denial of benefits through cost-bearing**

Even if we grant that some risky health affecting behaviours are intrinsically immoral – whether for Kantian or Aristotelian reasons – it is still necessary to establish that people who engage in these behaviours should be punished or sanctioned or denied a benefit for doing so and that the state has the right and the duty to do this. It is also necessary to establish that the punishment or sanction or denial of benefit that is owed can legitimately take the form of cost bearing. In other words, premises five and six of

the argument outlined above also need to be defended if the moralistic desert argument is going to be successful in defending cost bearing claims in relation to risky health affecting choices.

When people perform actions that are intrinsically immoral two kinds of arguments are classically deployed to defend the claim that those who commit such acts should be punished or sanctioned or denied a benefit. The first argument is consequentialist in nature and rests on the assumption that imposing some kind of penalty will increase net utility by reforming those who have committed the act and by deterring people who might otherwise commit the act (Wilson 2002). The second argument is retributive in nature and rests on the assumption that some kind of response to an immoral act is warranted even if the response decreases net utility (Cragg 1992).

In this section I will stick to the retributive approach because there is an intimate link between theories of retributive justice and the concept of moralistic desert and because consequentialist arguments do not fit well with non-consequentialist claims about the intrinsic immorality of some risky behaviour.<sup>121</sup> Moreover, I think that it is some notion of retribution which is often doing the work when people claim that those who engage in certain types of risky health affecting behaviours ought to bear costs. Harris (1985) agrees with this claim and he argues that people who wish to deny access to health care to patients on the basis of responsibility judgements are aiming to “*punish*” what they perceive as immoral behaviour for retributive reasons.

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<sup>121</sup> In other words, there is something rather odd about the idea that a consequentialist argument about imposing penalties should be employed in a situation where the reason for imposing the penalty is related to non-consequentialist claims about the intrinsic, rather than instrumental, immorality of a given behaviour.

Unfortunately, the principle of retributive justice is rather difficult to articulate. A renowned legal scholar simply claims that a retributive theory of punishment seeks to justify punishment in terms of a cluster of moral concepts that include: “*rights, deserts, merit, moral responsibility, justice and respect for autonomy*” (Murphy 1993). This is rather uninformative, but the broad definition reflects the fact that different versions of retributive justice place greater weight on different elements of this cluster and there is no consensus about which approach is most valid. Nonetheless, the dominant theories of retributivism are probably the “*reciprocity account*” and the “*respect for rationality account*” (Duff 1993). Both of these theories derive from Kant’s theory of punishment, but they have also recently been articulated and defended by a number of contemporary legal scholars.

The key claim underlying the reciprocity account is that retribution is necessary because it *rebalances* the scales of justice (Murphy 1993).<sup>122</sup> This rebalancing is needed because people who engage in intrinsically immoral actions gain some kind of benefit or advantage that they do not deserve. The benefit may be material in nature, but most scholars define the benefit as the advantage gained when an individual does not submit to some moral or legal law when others do so. In other words, the benefit is the advantage gained from a failure of reciprocation. Punishment or sanction or a denial of benefit then becomes necessary because it removes the underserved benefit by imposing a penalty that re-balances the harm caused by the initial action (Cragg 1992).

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<sup>122</sup> Kant specifically argues that punishment helps to ensure that “*the pointer of the scale of justice is made to incline no more to side than to the other*” (Kant 1996).

The main claim underlying the rationality account, meanwhile, is that punishment or sanction or denial of benefit is justified because it ensures that people are treated as rational beings and ends in themselves (Kant 1996). The basis of this claim has to do with the idea that when a rational person treats others in a certain way they essentially declare that, in their judgment, this is the way that people should be treated. Thus, in order to respect the rationality of the person who has committed the immoral behaviour it is necessary to treat them in the same way that they treated others and so, if someone harms another person, they should be harmed in turn. In this way we are allowing the person who commits the harm to determine how they wish to be treated and, in this way, we respect their rational judgment by allowing this to determine how they are treated (Rachels 2003).<sup>123</sup>

Both of these approaches may be used to defend the claim that people who engage in risky health affecting behaviours that harm other people ought to be made to bear a cost. This is because bearing a cost will help to nullify any advantage gained when people harm other people and it will also ensure that people are treated in the way that they treated others. The German legislation that I discussed in previous chapters clearly states that people who are injured as a consequence of *criminal behaviour* should have to bear some health costs as a result and it is possible that the chief rationale for this is retributive in nature (Schmidt 2007).

However, as we have seen, most risky health affecting behaviours are intrinsically immoral because they harm the self rather than other people and it is not clear that either the reciprocity account or the respect for rationality account can ground the

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<sup>123</sup> Or, as Kant (1996) puts it, “*his own evil deed draws the punishment on himself*”.

claim that people who engage in self harming behaviour deserve to be punished or sanctioned denied a benefit. The reciprocity account fails to apply in the case of self harming behaviour because this theory is firmly based on the idea that some people gain a benefit over other people when they ignore certain moral or legal laws, but this is ostensibly not the case where the allegedly immoral behaviour does not harm other people. There may also be some difficulty with applying the “respect for rationality” conception of retributive justice to self harming cases because the account is based on the way in which individuals treat other people.

Nonetheless, it may be possible to argue that those who self-harm upset the scales of justice in some sense and that cost bearing may be needed in order to rebalance these scales. Likewise, a penalty may be justified on the basis that people who harm themselves are, in effect, declaring that this is how they should be treated. This might imply that if we fail to penalise such behaviour we would undermine the respect that the self-harmer is due in virtue of his or her rationality. I must admit that I am far from sure that these arguments will succeed. However, for those who think that people who take certain kinds of risks with their health deserve to bear a cost on retributive grounds, some such argument will need to be developed to explain how retributive concepts can apply in self-harming cases.

It is worth noting at this stage that Kant (1996) himself was opposed to the idea that perfect duties to oneself – which included duties not to cause harm to oneself for no good reason – should be prohibited or punished. He firmly believed that these duties had to be self-imposed and self-enforced because if they were enforced via an external agency they would lose their value (Denis 2010). They would lose their

value, in part, because the use of external force in these cases would undermine people's ability to act autonomously. This, in turn, would be problematic because moral action, in Kant's eyes, depends on people using their capacity for freedom and rationality to act in ways that are in accordance with the moral law (Wood 2007). In fact, Kant explicitly opposed the idea that the state should interfere with people who harm themselves by intoxicating themselves with food and wine and he argued that the state should neither penalise these individuals nor prohibit them from harming themselves if that is what they wished to do (Denis 2010). However, though Kant did not think that the principle of retributive justice should be applied in these cases where people harm the self I have tried to show that such an approach is at least plausible on Kantian grounds.

The idea that states should intervene in order to penalise people who harm themselves as opposed to people who harm other people is also problematic because it runs headlong into a very powerful liberal objection known as the "*harm argument*". The classical statement of the harm objection is Mill's and I will quote the relevant passage in full here:

*"The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of*

*others, to do so would be wise, or even right...The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns him, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign” (Mill 1998).*

States often interfere with people’s lives either for paternalistic reasons or in order to penalise people for behaving immorally even when behaviour only causes harm to the perpetrator. But just because this is common practice does not mean that it is right. Moreover, as Mill expounded very eloquently over a century ago there are many reasons why government intervention is unacceptable when the goal is either to protect people from themselves or to punish immoral behaviour which only harms the perpetrator. One key reason for this is the massive amount of disutility that would result if the state trammelled on people freedom in this way. Another reason has to do with the fact that allowing the state to defend one certain conception of the good can lead to widespread abuse and the “*tyranny of the majority*”.

In sum, we can conclude that there are powerful consequentialist and non-consequentialist reasons for not allowing the state to interfere by imposing penalties on those who take risks with their own health. This is not to say that these objections will prove fatal to the moralistic-desert argument, but those who wish to defend this argument will have to address these objections and I am uncertain that a plausible counter-argument can be mounted.



It should also be borne in mind that even if the retributive account can be relied upon to defend the claim that people who behave in an intrinsically immoral way deserve some kind of penalty this account also needs to explain why the penalty that needs to be imposed could (or should) take the form of *cost bearing*. The point being that all sorts of responses are possible when someone commits an intrinsically immoral act and we need a way of determining which kind of responses are permissible and whether certain kinds of responses are especially desirable.

As it happens, all theories of retributive justice are firmly committed to the proposition that the nature and severity of the response to an intrinsically immoral act should be proportional to the nature and severity of the wrongdoing – and some also talk of the need for the punishment to be apt in some sense (Corlett 2006). The question for the retributive theorist then is whether bearing health costs is a proportional and apt response to a risky health affecting behaviour.

At a very general level, it is possible to argue that requiring people to bear health care costs (broadly construed) is especially apt in the case of risky health affecting behaviour because there is some kind of “natural” match between taking a risk with one’s health and bearing a health care cost. For example, requiring an arsonist to bear the costs of his burns injury and requiring someone who consumes too many calories to bear the costs generated by his obesity does ensure that the cost is linked to the risk in a way that some will see as metaphysically profound.

Moreover, it may be argued that at least some forms of health care cost bearing are *proportional* to the nature of the immoral act performed. For example, requiring a

smoker to pay for lung cancer treatment via increased tax payments does seem like a proportional response if we think that smoking for no good reason is intrinsically immoral. Of course, some kinds of cost bearing will rarely, if ever, be proportional. For example, denying people who have failed to exercise regularly access to any form of healthcare will be a disproportional response because this would be tantamount to capital punishment. However, some forms of cost bearing do seem reasonable both in terms of aptness and proportionality and, thus, *prima facie* defensible from the retributive perspective.

### **6.2.2.3 Desert: concluding thoughts**

I have argued above that many people openly espouse the moralistic-desert argument whilst others secretly (or unintentionally) rely on this argument too without declaring (or realising) that they do so. I have also argued that this defence of cost bearing is susceptible to a whole range of powerful objections. In particular, the argument is vulnerable to the claim that self harming behaviours are not, in fact, intrinsically immoral and that, even if they are, the state has no right to intervene by requiring people to bear costs in such cases.

I would also add, at this stage, that the moralistic desert argument might be considered vulnerable because it is committed to cost bearing even in situations where health care resource are abundant. It is committed to this conclusion because neither the immorality of a risky health affecting behaviours nor the retributive motivation for imposing penalties for engaging in that behaviour depends on circumstantial factors like the availability of health care resources.

Not everyone will regard this as an especially troubling objection, but for many the fact that this is true will serve to undermine the normative claims of this particular approach to cost bearing. Golan (2010), for example, argues that “*in a Utopian context of unlimited healthcare resources, personal responsibility for one’s own ill-health would be unlikely to gain widespread acceptance*” and he might well have added that even if people would still support cost bearing in these contexts there is something normatively perverse about this.

On the other hand, the moralistic-desert approach does succeed in mapping on to many people’s intuition that certain kinds of risky health affecting behaviours (e.g. altruistic risk taking) should not be penalised whereas other kinds of risky health affecting behaviours (e.g. consumption of recreational drugs) should be penalised. This may not necessarily be an advantage because it may be that most people’s moral intuitions are either wrong or can be explained on the basis of some kind of utilitarian explanation. However, the fact that this approach fits with people’s intuitions gives this account further *prima facie* plausibility.

### **6.3 Expected consequences, autonomy and cost-bearing**

The second normative defence of cost bearing that I will explore is the “expected consequences” approach. This account offers a way of side-stepping many of the objections levelled at the desert account because it does not rely on the proposition that there is anything intrinsically morally wrong with most risky health affecting or on the proposition that people should bear costs for retributive reasons. Instead, the argument relies on the claims that autonomy is – and ought to be – highly cherished

and that autonomy cannot be properly valued unless people bear the expected consequences of actions that they are morally responsible for choosing. More specifically, the argument runs as follows:

1. Autonomy is highly valuable.
2. Autonomy can only be properly valued if people experience the expected consequences of their autonomous actions.
3. The state must ensure that autonomy is valued by ensuring that people experience the expected consequences of their choices.
4. Health care cost bearing is an expected consequence of taking risks with one's health.
5. *Therefore*, the state must ensure that those who take risks with their health bear the costs of their choices.

I do not claim that the expected consequences argument is popular either amongst the lay public or amongst philosophers. Nonetheless, I will explore this normative defence because it offers an interesting alternative to some of the more traditional approaches that I will discuss in this chapter and it also rests upon a value (i.e. autonomy) for which there *is* broad and powerful support amongst the lay public and philosophers alike.

### **6.3.1 The high value of autonomy**

The first premise of the expected consequences argument is relatively uncontroversial. Philosophers from across the normative divide concur that the

capacity of rational human beings to make free decisions and to “govern” themselves is important – even if they disagree about why, exactly, autonomy matters. It is also true to say that in most liberal countries there is a strong commitment to autonomy even amongst sub-groups of the population who place much emphasis on communitarian concepts. This means that there is something of an overlapping consensus about the value of autonomy amongst philosophers and lay-people.

Of course, just because a majority of people value something does not make that thing valuable, but there are sufficient reasons to believe that autonomy is independently valuable and for the rest of this section I will simply assume that this is the case.

### **6.3.2 Autonomy and expected consequences**

The second premise of the expected consequences argument – i.e. that autonomy cannot be properly valued unless people experience the full (negative and positive) expected consequences of their actions – is likely to prove much more controversial than the first and many will balk at the claim that autonomy’s value can only be realised if people experience the expected consequences of their choices.

In response to these sceptical voices, Sher (1987) has argued that experiencing the expected consequences of an autonomous action *is* integral to the meaning and value of autonomy itself and he also argues that if people do not experience the expected consequences of their action their autonomy will necessarily be diminished. In a similar vein, Simon (1979) suggests that if we fail to ensure that the fate of free people is determined by their own purposes, intentions and judgements (and that they

experience that which they are expecting to experience) we will fail to treat human beings as persons. Moreover, Brown (2005) argues that if the link between our actions and their expected consequences is cut, autonomy becomes a hollow and relatively meaningless value and he suggests that “*expecting people to take individual responsibility for the success or failure of their own lives is an important way of showing respect for their competence as freethinking agents*”.

But why should we think that there is such a strong link between autonomy and the expected consequences of an action? The argument starts with the observation that when we deliberate and seek to act autonomously we weigh the consequences that might result from our actions and, in some cases, the expected consequences of our actions are part of what we choose when we decide on a given course of action. In other words, we choose certain actions in certain situations partly because they have certain (expected) consequences.

However, it may be said that there is a direct link between acting autonomously and experiencing the expected consequences of those actions because our autonomous choices encompass not just our choices but also the expected consequences of those choices. Indeed, in a very real sense, the connection between autonomous acts and the consequences of those acts are internal to the concept of autonomy itself.

Moreover, if we accept this account we can argue that the value which is attached to autonomous choices is carried over to the consequences of the choice. This is because some of the consequences of the choices that we make are an integral part of what we choose when we make autonomous decisions and it would be “*quite arbitrary to say*

*that it is good that the agent perform the act he has chosen, but not good that he enjoy or suffer the act's predictable consequences"* (Sher 1987). This, in turn, is because choice encompasses both the acts that we choose to engage in and the consequences of those acts and so the value which we attach to the performance of autonomous choice naturally belongs to both the act and the consequence of the act.

If we accept these premises we can then conclude that if the link between choices and expected outcomes is broken – i.e. if people are effectively prevented from experiencing or realising the expected consequences of their actions – then their autonomy will necessarily be severely curtailed and will be worth relatively little. This is not to say that people's choices will no longer be autonomous in any sense, but rather that the autonomy that remains will be a mere shell of what autonomy can (and should) be. Thus, if the very first premise of the expected consequences defence of cost bearing is true – viz. that autonomy is highly valuable – we seem committed to want to live in a world where our choices have consequences and in a world where people experience the (expected) consequences of the autonomous actions for which they are morally responsible.

This argument may appear to be vulnerable to the objection that the traditional concept of autonomy deals primarily with the freedom to choose rather than the freedom to see one's choices bear fruit. If we are free and rational agents and make a decision after due deliberation (i.e. if we are morally responsible for our choice) we are usually regarded as being autonomous *regardless* of whether our decision actually has any effect on the world.

When sheer luck, or the behaviour of other people, unexpectedly supervenes and blocks some of the expected consequences of our actions we do not suddenly think that our decisions lacked autonomy. In fact, given that events that we do not control regularly prevent the expected consequences of our actions from occurring, we might have to relegate the whole notion of autonomy to the margins of our moral world if we were to accept that autonomy is annihilated whenever unexpected consequences disrupt our goals.

In response it may be said that this objection simply misses the point. The expected consequences account does not claim that people cannot be autonomous if the expected consequences of their choices fail to materialise.<sup>124</sup> Rather, the claim that is being made is that it is important that expected consequences follow from our autonomous choices as much as possible otherwise our autonomy will come to mean very little in reality. When luck “gets in the way” we may rightly conclude that people’s autonomy has been somewhat thwarted or that the full value of autonomous choice has not been realised, but we are not committed to claiming that autonomy itself has been entirely destroyed. As such, this particular objection does not undermine the expected consequence argument.

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<sup>124</sup> This is because the expected consequences argument does not claim that experiencing the expected outcome is *constitutive* of autonomy. It may be argued that experiencing the expected outcome does constitute autonomy, but it would be hard to justify this claim because, in very many cases, the expected outcome does not occur yet we do not regard our actions as heteronomous as a consequence. For example if an individual, after much contemplation and a great deal of rational discussion, decided to take cocaine for the first time in his life it would seem odd to say that he had not made an autonomous decision to take cocaine if it later transpired that he accidentally consume heroin instead.



It may also be argued that the expected consequences account is vulnerable to another objection, *viz.* that not all the expected consequences of our choices inherit the autonomy-value of the choices that we make. For example, most people would deny that women who choose to fall pregnant or firemen who suffer burns injuries whilst rescuing other people should bear the expected consequences of their choices.

Likewise, in situations where the risks taken are a “*necessary element of all reasonable lives*” (such as the “everyday” risks that I discussed in chapter 4) we do not usually think that risk takers should bear the expected costs of their choices (Ibid, p 46). Furthermore, if an individual is coerced into taking a risk we do not normally believe that this individual should bear the expected consequences of his choice.

But why should we think that the autonomy value of the choices that we make do not transmit to the expected consequences in these kinds of cases? In the case of coercion the reason is obvious. The issue in these situations is not that the link between the value of choice and the expected consequences is broken. Rather, the problem is that the original choice was not an autonomous choice and thus there was no autonomy-value to be transmitted from the “choice” to the expected consequence in the first place.

However, in the case of altruistic risk taking or in the case of risks taken for socially valuable reasons I do not see why the autonomy-value of the choices that we make is not transmit to the expected consequences of the choice. As long as the choices are *autonomous* choices the expected consequences account implies that the autonomy-value of these choices are transmitted to the consequences. Thus, there is no way of escaping the conclusion that costs should be borne in these situations because there

are no grounds *within* the expected consequences account to accommodate these ideas. In other words, the adoption of a pluralistic approach which takes account of values other than autonomy is the only way to “save” the expected consequences account from the conclusion that pregnant women and firemen should not bear the costs of their choices.

Where “necessary” risks are involved, the situation is a little less clear. In these cases we might argue that the autonomy value is not transmitted from the choice to the consequences because the risk taken is necessary to enable most other autonomous choices to be made. In a society where driving is “essential” for people to live reasonably full lives the decision to take the risk of driving (sensibly) is necessary because without taking this risk our ability to engage in other autonomous choices will be curtailed. If we accept this we may then be able to argue that where a choice is necessary in this sense it is not a “*meaningful expression of our will*” and so the choice confers little value on the expected consequences (Ibid, p 49). Thus, if a careful driver is injured in a road traffic accident he should not have to bear any health costs.

However, although the expected consequences account is premised on the idea that autonomy is valuable, it does not necessarily follow that the expected consequences argument is committed to the claim that actions which maximise the value of autonomy should not be subject to the second premise of the argument. Indeed, this is not the case because it is vital for people to experience the positive *and* the negative expected consequences of all their choices if autonomy is to be truly valued. Consequently, the claim that we should not make people bear the expected costs of

their autonomous decisions when these autonomous decisions are necessary to open up other autonomous decisions needs to be established independently of the expected consequences argument itself. Of course, there is no reason why a new premise could not be added to the argument, but this new premise will have to rely on a principle of maximisation which is not inherent to the expected consequences account.<sup>125</sup>

What this means, in effect, is that the expected consequences argument – in its pure form – cannot distinguish between different types of risky health affecting behaviour when it comes to cost bearing. In other words, this approach is just as likely to demand cost-bearing where people engage in altruistic, socially valuable and “everyday” risks as it is where people smoke, take drugs or consume too much meat for hedonistic (or other) reasons. It would beg the question to assume that this “failure” undermined the argument, but the fact that the expected consequences account does not reflect most people’s intuitions on this matter may be problematic.

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<sup>125</sup> In a similar vein it may be argued that if we really care about autonomy we should not make people bear costs if doing so means that they lose more autonomy. For example, if the form that cost bearing takes would imply that people will die prematurely, the overall loss of autonomy that will result will be much higher than if people were not forced to bear costs. Dead people, after all, have no ability to act autonomously. My response is identical to the response that I have just given. Firstly, experiencing the expected consequences of our actions, including negative consequences, is essential if autonomy is to have any real value. Secondly, we would need to include a “maximisation of autonomy” principle into the argument in order to defend this position and although this could be done it would not stem from inside the expected consequence rationale. As it happens, this approach might still provide a defence of some forms of cost bearing (e.g. taxation of risky behaviour) – though not others (e.g. denial of access to healthcare) – but I will not explore this particular argument any further in this thesis.

### 6.3.3 Should the state ensure that autonomy is valued?

Even if we grant that autonomy is not properly valued unless people experience the expected consequences of their choices it is another matter entirely whether the state should intervene to ensure that this occurs. In some cases the state will not need to intervene because people will “naturally” experience the consequences of their choices. For example, some people who choose to smoke develop lung cancer and the government need not intervene in any way to ensure that this happens. In these kinds of situations the state must simply resist the temptation to prevent people from experiencing the expected, negative, consequences of their behaviours.<sup>126</sup>

However, in other situations, the state will have to intervene if people are to experience the expected consequence of their choices. If the expected consequence of developing a disease after taking a risk includes the expectation of bearing health costs, for example, then governments will have to act to ensure that the health system in operation forces people who developed such diseases to pay the expected health cost.

The *prima facie* problem with this idea is that state intervention in the name of autonomy has a paradoxical ring to it. States regularly intervenes in our lives to

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<sup>126</sup> Having said as much it is not entirely clear what would count as a “natural” expected consequence. For example, it is not clear whether lung cancer is an expected consequence of smoking. Certainly, smokers are much more likely to get lung cancer than non-smokers, but fewer than 50% of smokers will develop this condition which means, on the balance of probability, developing lung cancer may not be expected. However, this problem need not detain us here because what I am interested in is the issue of whether cost bearing in the event of a disease developing is an expected consequence rather than whether the disease itself is expected.

ensure that we do not infringe other people's autonomy, but what we are discussing here is state intervention to protect the value of autonomy itself and this does not seem, on the face of it, a legitimate task for the state. One reason for this is because state intervention to protect the value of autonomy sounds very much like state intervention to protect one specific conception of the good. It may be argued that autonomy is a "thin" conception of the good and that there is an overlapping consensus about the value of this particular value. Moreover, allowing states to protect autonomy would enable a range of "thicker" conceptions of the good to be protected from state interference.

However, some people do not regard autonomy as an especially important value and they may resent the idea that they have to bear health costs in order to protect a value that they do not especially care about. From these people's point of view, state intervention to protect the value of autonomy will be as unjustified as state intervention to punish people for their intrinsically immoral behaviour.

In response to this objection we have to recognise that although there is a real sense in which autonomy is a "thinner" value in some sense and that there may be more of a justification for the state to intervene to protect this value, we cannot entirely escape from the fact that some people (and maybe even entire cultures) would regard autonomy as a rather "thick" value. This means that the expected consequence account is vulnerable to the claim that state interference to defend cost bearing on the basis of autonomy-protection may not be legitimate – even though this objection has less bite than it does in the case of state intervention in the name of penalising intrinsically immoral behaviour.

#### 6.3.4 Are health costs expected consequences?

Although the penultimate premise of the expected consequences argument is open to serious objection, it is the last premise of the argument that is the most problematic. The last premise states that health care cost bearing is an expected consequence of risky health affecting choices. The problem with this is that people's expectations will entirely depend on whether bearing costs is an expected consequence within the society that people live in.

In many countries people who fall ill do expect to pay some kind of health cost. In most developing countries people expect to pay for most of their treatment when they fall ill and they also expect to be denied access to treatment if they cannot afford to pay. However, in most developed countries people who fall ill expect that health care will be provided free of charge and that they won't have to bear any kind of cost even if they were causally and morally responsible for their ill-health.<sup>127</sup> In the UK, for example, cost bearing, would *not* be an expected consequence even if people were ill because they took risks with their health because the NHS does not (currently) operate on this basis.

The health system in the UK and elsewhere could be changed so that people who take risks with their health do bear costs and if this was done people living in these countries would then be expected to bear the consequences of their choices. However, it is not clear what the justification for this change would be. Certainly, the expected consequences argument could not itself be the source of this justification because the

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<sup>127</sup> Health care has to be paid for somehow, but it is free at the point of need in many developing countries and this is true even if the patient has never paid any tax.

argument does not tell us what people *should* expect. Instead, it simply tells us that *if* people expect a certain consequence then they should have to bear that consequence in order that autonomy is properly valued.

This is a major problem because the goal of the expected consequence account is to provide an independent defence of cost bearing, but the most that the argument can establish is a defence of cost bearing once a society has specified, on some other normative grounds, that people should bear the cost of their choices.<sup>128</sup> If the expected consequences account cannot provide an independent account of why people who engage in risky health affecting behaviour should bear the costs of their choices then its usefulness as a normative theory is very much in doubt.

In response it may be possible to argue that cost bearing is a “natural” expected consequence of risky health affecting behaviour in just the same way that ill-health might be a natural consequence of taking risks. However, aside from the fact that this is a rather dubious idea, even if we accept that it is true, it is not clear how this really helps. If cost bearing is a natural cost, but society has previously decided to ensure that these natural costs should not be borne by those who take risks with their health, then the fact that bearing costs is natural seems irrelevant because people who take risks will not expect to bear these natural costs. Moreover, it is not clear which kind of cost bearing is, in fact, natural. The only obvious contender would be denial of access

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<sup>128</sup> The nature of the costs that people have to bear would also have to depend on what people actually expect. This means that the expected consequences account cannot independently specify which kind of cost bearing policy should be adopted (e.g. a taxation or a denial of access policy) either.

to health care (rather than an “artificial” taxation policy) but the sense in which denial of access is the natural form of cost bearing is very unclear.

This means that the expected consequences can only justify cost bearing if cost bearing is already an expected consequence of people’s choices. This may not prove to be a fatal problem, but it does undermine the power of the argument and it also leaves it dependent on some further normative argument which would need to furnish us with a reason to believe that the expectation of cost bearing was, in fact, something which people *should* expect.

I would also like to add at this stage that there is also a potentially serious ambiguity about the claim that people ought to bear the expected consequences of their choices. The ambiguity relates to the fact that it is not clear *who* it is that needs to be expecting a given consequence. Do we mean that the individual who must bear the cost must have expected this consequence or is it sufficient for the individual to live in a society where this is the general expectation?

If we say the individual must expect this consequence then, aside from the difficulty that it would be hard to know what each individual actually did expect, it would imply that people could avoid having to bear costs by deliberately refusing to expect the expectations that society generally expects. If, on the other hand, we argue that what matters is the general expectation in society we would have to accept that some individuals would have to bear costs even though they did not expect to do so and this would be problematic because the autonomy-value of *their* choices would not be transferred to the outcomes that they end up experiencing.



### 6.3.5 Expected consequences: concluding thoughts

The expected consequences account offers a very different defence of cost bearing to the moralistic desert argument because it is not based on the claim that there is anything intrinsically wrong with taking risks. It is also a rather novel approach which may appeal to many people because it rests on the claim that autonomy has special value. However, the expected consequence approach is not without its problems. In particular, it is very vulnerable to the fact that this approach cannot *independently* ground the claim that people should bear costs because it can only demonstrate that people should bear costs if bearing costs is something that people actually expect.

It is also worth reiterating that the expected consequences account cannot make distinctions between different kinds of risk (e.g. risks taken for altruistic reasons and risk taken for hedonistic reasons) and so cannot explain many of our basic intuitions about who should bear costs.<sup>129</sup> Moreover, the expected consequences account cannot be regarded as “value neutral” defence of cost bearing because it is premised on the claim that autonomy is an important value. Thus, in a sense, the expected consequences account suffers from the worst of two worlds: it is not neutral between different conceptions of the good but, equally, it cannot distinguish between different kinds of risky health affecting behaviours. Contrast this with the moralistic desert argument which, like the expected consequences argument, abandons liberal

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<sup>129</sup> This is not necessarily a problem because our intuitions may be “wrong”, but it must still give us some pause for thought.

neutrality but, in return, is able to explain to make distinctions between risky behaviours which reflect most people's moral intuitions.<sup>130</sup>

The last point I would like to make is that the expected consequences account would, like the moralistic desert approach, require people to bear costs even in situations where resources were abundant as long as people still expected to bear costs in these kinds of situations. Admittedly, if resource were abundant it is less likely that societies would require people who took risks to bear costs, but if they did the expected consequences account would be committed to claim that these costs should be borne even if resource were not scarce. This is not a “real-world” problem, but as with the moralistic desert argument many will see this as a serious objection to this particular approach.

#### **6.4 The Rights-Harm Argument**

The rights-harm argument, like the expected consequences argument, takes a different approach to the moralistic desert argument because it is not premised on the idea that there is anything intrinsically wrong with taking certain kinds of risks or that we need to rely on retributive concepts of justice in order to defend cost bearing. However, it also differs from the expected consequence account because it makes no appeal to the value of autonomy or the importance of ensuring that people experience the expected consequences of their choices.

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<sup>130</sup> The expected consequences account also suffers from the disadvantage that it does not reflect the views of most people who support cost-bearing. I cannot prove that this is the case, but there is little evidence to suggest that people defend health care cost bearing in the name of autonomy and expected consequences. That does not mean that they should not adopt this approach, but from the policy makers perspective it might be problematic if few people subscribe to this particular argument.

Instead, the rights-harm argument is based on the claim that people should be forced to bear the costs of at least some of their health affecting choices *if* doing otherwise would involve the consumption of too many scarce healthcare resources and, thus, the violation of other people's positive right to health care. In summary, the right-harm argument runs as follows:

1. All citizens have a (limited and forfeitable) positive right to healthcare – including a (limited and forfeitable) right to healthcare *without having to bear costs*.
2. Citizens who have the ability to do so have a duty to provide the resources needed to ensure that their fellow citizens receive the healthcare that they are owed by virtue of their (limited and forfeitable) positive right to healthcare.
3. Citizens who are morally responsible for taking risks with their health have a duty to bear costs if failing to do so would harm other people by violating their ability to access the healthcare that they are owed by virtue of their (limited and forfeitable) positive right to healthcare.
4. The state has the right and the duty to prevent rights violations, including the violation of people's (limited and forfeitable) positive right to healthcare.
5. *Therefore*, citizens who are morally responsible for taking risks with their health may be required to bear some of the costs of their health affecting choices in situations of scarcity.

As we can see the rights-harm defence of cost bearing is complex and it will take time to unpack it. However, if the argument is sound it will serve as a powerful defence of

cost bearing not only because the concept of rights and duties are deeply embedded in the culture of many modern societies – so much so that many health policies now make reference to the moral (and legal) right to health – but also because there are many powerful normative reasons to think that rights trump other aspects of the normative fabric of our world.

#### **6.4.1 Positive rights to health and corresponding duties**

Civil and political rights are well established at law and many philosophers and lay people believe that people have moral versions of these legal rights too (Wolff 2012). International law also makes it clear that people have legal forms of social, economic and cultural rights – including the right to health. Indeed, a legal right to health has been embodied in international law for over half a century via Article 25(1) of the Universal Declaration of Human Rights (1948) which states that people have a “*right to a standard of living adequate for health*”.<sup>131</sup> The International Covenant on Economic, Social and Cultural Rights (1976) also makes it clear that people have a legal right to “*the highest attainable standard of physical and mental health*”.

Interestingly, a number of policy documents assume that a *moral* right to health also exists. For example, the NHS Constitution (2009) explicitly talks about the moral rights of patients to access a wide range of health services and the American Medical Associations Patient's Bill of Rights states clearly that patients have a moral “*right to essential health care*”.<sup>132</sup> But, even if many policymakers, health care professionals

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<sup>131</sup> This includes a “*right to medical care*”.

<sup>132</sup> The World Health Organization Constitution (1946) also notes that “*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being*”.

and patients now believe that they have a moral right to health it is less clear whether this claim is philosophically defensible.<sup>133</sup>

There are many different ways of defending the proposition that people have a moral right to health. Some philosophers argue that a human right to health can be defended on the grounds that giving people rights will maximise overall levels of welfare whilst others argue that it can be defended on the basis of our common humanity, or on some notion of human dignity, or because these rights spring from our nature as human agents (Wolff 2012). Theological philosophers might also argue that a human right to health is part of a God-given set of rights. However, though I do not wish to argue here that these approaches are unsound, I think that the most powerful defence of the human right to health is based on the idea that health is a *vital interest* and it is this defence of human rights that I will explore further in this chapter.

There are three primary reasons for claiming that health is a vital interest. Firstly, health is intrinsically valuable. Secondly, health is a basic need. Thirdly, health is necessary for fair equality of opportunity. The claim that health is intrinsically valuable is contestable, but there is a very broad consensus that health is extremely valuable for its own sake and if we have reason to think that anything has intrinsic value then we have good reason to think that health counts as one of these things. The second claim is also fairly uncontroversial. Basic needs are those things which are *“functionally necessary for the most fundamental projects involved in living a human*

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<sup>133</sup> Critically the moral right to health is usually seen as a positive, not a negative, right to health. A negative right to health would only imply that people have a duty to not prevent people from taking steps to be healthy. A positive right to health, as we shall see, implies that people have more onerous duties to ensure that people’s right to health is protected.

*life*” and there can be little doubt that health fits into this category (Dennier 2005).

Finally, Daniels (1985) has argued convincingly that health is necessary to protect our normal functioning and our opportunities to form, pursue and revise our life-plans and, as a result, we can say that health protects our vital interests because health is necessary for fair equality of opportunity.

Many people will accept that health is intrinsically valuable, that it is a basic need and that it is needed for fair equality of opportunity but will not agree that health is a human right. Some of those who reject this idea do so at a very general level. For example, Bentham believed that the concept of a natural moral right is simply “*nonsense upon stilts*” and subsequent utilitarians have followed suit.<sup>134</sup> Other philosophers have offered much more specific critiques of the human right to health claim. In this chapter I will not attempt to deal with any general criticisms of the “moral rights” approach, but I will spend some time analysing the more specific critiques that have been raised against the concept of moral rights to health.

The first specific objection to any human right to health claim is that the right to *health* amounts to be a right to be *healthy*. This, it is claimed, is problematic because if the right to health is a right to be healthy then the right to health can never be achieved because we lack the resources and the technology to ensure that every disease and injury can be cured (Wolff 2012). However, I see no reason to assume that the right to be health must be equated with the right to be healthy. International legal documents explicitly state that the *legal* right to health should not be interpreted as a right to be healthy and no philosopher is likely to seriously argue that the moral

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<sup>134</sup> Utilitarians might still defend the concept of legal right and even a non-natural moral right, but only if the adoption of such rights maximised utility.

right to health should be interpreted in this way either. Thus, it is fair to say that this particular objection is something of a “straw man objection” and I will not explore it any further here.

I will also stipulate at this point that I interpret the right to health to mean a right to healthcare. Others have argued that the right to health is broader than this and should include the right to all of the determinants of health rather than just healthcare (Beitz 2009). Moreover, in international law, the legal right to health is defined as a right to “*a variety of goods, facilities, services, and conditions*” necessary for the realisation of health and this is interpreted to mean much more than a simple right to “*medical care*” (International Covenant on Economic, Social and Cultural Rights 1976). I will adopt the more conservative interpretation of health rights here, but my decision should not be interpreted to mean that I reject the wider claim about the right to all the determinants of health. Rather my decisions is based on the necessity of keeping an already complicated argument as simple as possible.

The second specific objection that is often levelled at the right to health – and the right to healthcare – is that there cannot be such a right because it is impossible to determine the scope of the right (Denier 2005). In particular, it is claimed that it is impossible to determine how much healthcare people are owed.

It is unquestionably difficult to give a precise account of the scope of the right to health, but we can delimit the scope of the right by relying on the concept that I have claimed that the right itself is based upon – i.e. the concept of vital interests. If we adopt this approach we will be forced to conclude that the right to health does not

amount to a right to every possible form of healthcare because many forms of ill-health do not seriously affect our vital interests.<sup>135</sup> Instead, the right to health will be a *limited* right. However, although it will be hard to delimit the exact scope of the right to health using this method we should be able to specify the scope in broad terms and if we can do this then we can claim that the second objection can be overcome.<sup>136</sup>

The third objection that is often raised against the right to health is that the right to health cannot exist because, if it did, it would cause intractable “rights conflicts”. In particular, the existence of this right would create a clash between different positive rights and also between different positive and negative rights. The clash between the positive right to health care and other positive rights would occur because, if we accept that people have positive rights to health, we are also likely to think that people have a right to a range of other social, economic and cultural goods. For example, if we adopt the “vital interests” argument that underpins the right to health we are likely to believe that there is right to education since education is also a vital interest.

In response, I will firstly point out that just because positive rights would clash if they existed does not mean that they do not exist. Instead, the criticism ought to be that the rights exist but that the clashes between them cannot be resolved in a non-arbitrary manner. However, I also deny that this latter objection rings true because, once again,

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<sup>135</sup> For example, when people are infected with a rhinovirus and develop a common cold or when they develop a small lipoma on their skin I think it is reasonable to say that these types of ill-health (in most cases) do not affect people’s vital interests.

<sup>136</sup> The American Medical Association claims that the right to health is a right to “*essential*” healthcare – although the World Health Organizations (1946) claims that the right to health means a right to the “*highest attainable standard of health*”. I think that the “right” answer lies somewhere in between these claims, but I will not explore this matter further here.



we can rely on the concept of vital interests to help us establish some kind of hierarchy of rights. This is not to say that the right to health will always trump other rights – in fact it often will not – but it does mean that some kind of resolution to positive rights clashes is possible and that the right to some level of healthcare will do rather well in such clashes because health is often an especially vital interest.<sup>137</sup>

The clash between the positive right to health care and negative rights, meanwhile, will occur because the positive right to healthcare implies that other people have a positive duty to ensure that this right is upheld.<sup>138</sup> In particular, the positive right to health implies that other people have a duty to ensure that there are enough health care resources available to provide care to those who have a right to such care and a duty to bear one's own health costs (in situations where the cost only exists because one was morally responsible for taking risks) if failing to do so will lead to a consumption of resources which will harm other people by depriving them of the healthcare that they have a right to (Denier 2005).<sup>139 140</sup>

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<sup>137</sup> If we include the right to the social determinants of health in the right to health then the right to education will also be partially subsumed under the right to health.

<sup>138</sup> These duties follow from the proposition that people have a right to health because of the conceptual link that exists between certain kinds of rights and duties. If people have claim rights then other people *must* have duties towards those who have these rights. Thus, if I am right to argue that we all have a right to healthcare it follows by necessity that at least one other person has a duty to ensure that we receive the healthcare that we have a right to.

<sup>139</sup> Importantly, the rights-harm argument does not imply that people who are morally responsible must bear all the costs of their choices. Instead the claim is that beyond a certain threshold costs must be borne. The threshold itself will be defined by the level of care that people have a right to – and how expensive it proves to ensure that people who are not responsible for their ill-health get access to the care they need. This makes the cost that people who are responsible have to bear rather fluid and difficult to calculate, but given how expensive healthcare is it is likely that people who are morally responsible will have to bear quite a bit of their own costs if they develop expensive diseases as a result of their health affecting choices

Given the existence of these duties a conflict between people's positive right to healthcare and people's negative rights is inevitable. In particular, there will be conflict between some people's positive right to healthcare and other people's negative rights not to be economically productive and not to have to contribute a portion of their productive labour to other people. This is a very serious objection because these rights essentially amount to the right not to be forced to work when one does not want to and the right not to have to work for the sake of other people against one's will. To put it bluntly, if I have a positive right to health care it means that "*I am entitled to the time, the effort, the ability, the wealth, of whoever is going to be forced to provide that care*" (Kelley 1994).<sup>141</sup>

It is difficult to know how to respond to this objection because the issue here is not just the general problem that negative rights are usually considered to be more important than positive rights – a problem that, in some cases, can be overcome – but the more specific claim that the negative right to be free (i.e. the right not to be an economic slave of sorts) seems like a much more important right than the positive right to healthcare. Indeed, on the "vital interests" approach to rights it seems very reasonable to conclude that the right not to be a slave protects a much more vital interest than the right to receive healthcare.

This is not to deny that most people would benefit from having a positive right to health and that in some situations a right to health may be more vitally important than

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<sup>140</sup> It may also mean that people have a third duty – i.e. a duty to try and remain healthy enough to work productively. This is because people cannot fulfil their duties unless they can be productive. However, I will not explore this "duty to be healthy" in this thesis.

<sup>141</sup> Nozick (1977) famously describes some taxes – including taxes designed to provide health care to others – to be on a par with slave labour.

the right to freedom. For example, if not having access to healthcare is likely to be mortal then it could well be argued that the right to health is more important than the right to freedom. However, is it not just right-libertarians who will take issue with this claim and I admit that, in general, the right to freedom will be regarded by most people as a much more vital right than the right to health.

As such, this particular objection raises a very serious problem for the rights-harm defence of cost bearing. Ironically enough, right-libertarians might well be able to devise their own defence of cost bearing in relation to risky health affecting behaviours, but their claim that the negative right to freedom trumps (or destroys) people's positive right to health care – a claim which many people will surely support – means that the rights-harm argument might well come unstuck.

The last objection that I wish to discuss in this section does not challenge the existence or the relative importance of this right but rather the separate claim that the “right to health care without bearing costs” must be forfeitable (Denier 2005). If the rights-harm argument is to work, the right to health without bearing costs must be forfeitable otherwise no one could be required to bear the costs of their health care choices even if they were morally responsible for them and even if this would cause other people's right to health care to be violated.

The trouble with this claim is that it is likely to prove hugely controversial. In the academic literature the legal and moral right to free healthcare is never usually described as a right that can be forfeited or lost in any sense (Wolff 2012). There is no suggestion in the International Covenant on Economic, Social and Cultural Rights

(1976) that the legal right to health can be forfeited for *any* reason. Likewise, philosophers and policy makers who make reference to moral rights to health in their work do not regard these rights as forfeitable (Beitz 2009). Yet, the positive right to health care without bearing costs must be forfeitable if the existence of this right is to underpin a defence of cost bearing in relation to health affecting behaviour.

What then are we to say about this matter? Can a positive right to health care without cost bearing be forfeited? Contrary to what many writers claim, I think that this is possible. To begin with we should bear in mind that even (allegedly) lexically prior rights like first generation civil and political rights can be forfeited in certain circumstances. In times of war people's right to life can be forfeited and people's right to liberty can also be forfeited if they commit serious crimes.<sup>142</sup> As such, there is at least some reason to think that second generation rights could be forfeited in some situations. Moreover, as we have just seen, positive rights (if they exist) will often have to be forfeited when they clash with other negative and positive rights. For example, if there are not enough resources to ensure that the right to education and the right to health are fully protected then, in some situations, the right to health will have to be partially forfeited.

Of course, these arguments simply demonstrate that the right to health without cost bearing can be forfeited in certain situations not that the this right can be forfeited because the exercise of that right will violate other people's rights. However, I agree

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<sup>142</sup> Likewise, people who are infected with certain types of dangerous communicable infectious diseases are quarantined, investigated, screened and, in some countries, treated against their will in many jurisdictions even though this clearly involves a whole series of violations to fairly vital and basic rights including the right to bodily integrity and the right to freedom of movement (Herring 2008).

with Denier (2005) that “*just as a person can forfeit his or her right to liberty by criminal behaviour, one could argue that a person can forfeit his or her right to healthcare by failing to act responsibly*”. In fact, I can think of few better reasons to defend the claim that a positive right to healthcare without cost bearing must be forfeited than the fact that a failure to forfeit the right will violate other people’s positive rights in situations where those who must forfeit the right are morally responsible for putting themselves in this invidious position and where those who would otherwise be harmed if the risk takers do not bear costs are not morally responsible for needing health care.

#### **6.4.2 Does the state have the right and the duty to prevent rights violations?**

Even if we accept that people have positive moral rights to health care and that other people have corresponding duties both to add to the collective pool of resources and to bear costs in order to avoid diminishing this pool in certain circumstances we still need to establish that the state has the right to intervene to ensure that people’s rights are respected and that people fulfil their duties.

The defence of state intervention in the case of the rights-harm argument is, in principle, easier to justify than it was in the case of moralistic desert and expected consequences. This is because the goal of state intervention in this case is the prevention of rights violations. This is important because the prevention of rights violations is widely considered to be one of the most important roles that states can play. Moreover, this is a much more legitimate role than the goal of penalising immoral behaviour or even protecting the value of autonomy. This is because the aim

in this case is not to defend a thick or thin conception of the good but to defend a concept of “right” and this is an advantage because it means that the state is able to maintain neutrality between conceptions of the good. This, in turn, is important because it means that the position will be more defensible from a liberal perspective.<sup>143</sup>

#### **6.4.3 Rights Harm argument: concluding thoughts**

The rights-harm defence of cost-bearing is complicated and, as we have seen, a slew of objections can be raised against this approach to cost bearing. I have argued that some of these objections can be rebutted but that others are very powerful and are hard to side-step. In particular, the claim that there cannot be a positive right to health because such a right would violate people’s negative right not to work is a very serious one. As such, I agree with Wolff (2012) that much more philosophical work must be carried out if a successful defence of the right to health is going to be mounted. However, the concept of a positive moral right to health is already as much a part of political and social discourse about health care as is the concept of a legal right to health in international legal discourse and if these objections can be overcome then the rights-harm defence of cost bearing will resonate with many people and may prove to be very powerful.

Moreover, the rights-harm argument has one other important advantage over the moralistic-desert and expected consequences accounts: it does not require people to

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<sup>143</sup> Obviously, the state would also be committed to protecting people’s negative rights too and if we concede that people’s negative right not to work trumps people’s positive right to health care then we will be forced to conclude that the state must not protect people’s right to health. However, if we accept that the positive right to health trumps the negative right not to work then I think it is reasonable to argue that the state has the right (and the duty) to enforce cost bearing where needed.

bear costs in situations where resources are abundant. This is because, if resources were abundant, then it would not be possible for people to harm other people by consuming resources because there would always be plenty of resources left even after everyone had received the healthcare that they needed. Of course, in the real world health care resources are not abundant and nor are they every likely to be. Nonetheless, this feature of the argument does seem like an advantage because the very idea of making people bear costs if resources are abundant will seem repugnant to many.

However, the rights-harm argument is also lumbered, like the expected consequences account, with what many will regard as a major problem. This problem relates to the fact that the rights-harm approach cannot distinguish between people who take risks for reasonable or altruistic reasons and those who take risks for hedonistic reasons when it comes to determining who should bear costs. The rights-harm argument will require both pregnant women and smokers, for example, to bear costs even though this flies in the face of most people's intuitions.

The rights harm argument is also committed to one rather odd conclusion. If people who take risks actually contribute more to the pool of resources than people who do not take risks it may be that, in reality, they should not only not have to bear costs, but they might even have more of a right to health care without paying any kind of cost than non risk takers (Wilkinson).<sup>144</sup> *Prima facie* it may seem that this is simply a theoretical point, but because risk takers tend to die prematurely they tend to collect fewer social security payments in the form of pensions. Furthermore, they sometimes

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<sup>144</sup> McLachlan (1995) puts the point differently and asks whether risk takers who cost less money have the right to "*ask for a rebate?*".

cost the state less in health care spending terms because a substantial amount of health care spending is directed at the “very” old – i.e. at people who tend not to take risks and manage to live a long life as a result (Persaud 1995).<sup>145</sup>

Indeed, Baal *et al* (2008) argue that life time health costs are highest for the healthy (these were defined as non smokers with a “normal” body mass index), lowest for smokers and somewhere in between for the obese.<sup>146</sup> A number of studies have also suggested that smokers save money for the state because they have a cost-efficient mortality rate (Dietrich 2002; Hayashida et al 2010). In other words, “*the truly burdensome individual may be the unreasonably fit senior citizen who lives on for more than 30 years after retirement*” (Wikler 1978).

We have to be careful here because many of these calculations are based on the fact that some risk takers (most notably smokers) pay high levels of commodity taxes already. In other words, they already bear costs (in the form of taxes) and the real problem may be that they pay too much tax rather than the fact that they pay tax at all. To put it another way, if they stopped paying tax they really would become a net drain on resources and the rights-harm argument would then justify forcing them to pay some kind of cost.

However, if risk takers did not pay any taxes (or any other similar cost) and yet still contributed more resources to the social pool than they used it seems that these risk takers should not have to bear any costs because they do not harm other people by denying them resources that they had a right to. In fact, it may be non-risk takers who

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<sup>145</sup> This is partly because of the ubiquity and cost of treating dementia.

<sup>146</sup> Their data suggests that the lifetime health cost (from the age of 20 onwards) for these groups in the Netherlands was 281,000 Euro, 220,000 Euro and 250,000 Euro respectively.



should bear costs in this kind of situation rather than the risk takers. Again, this is not a likely scenario, but it is at least possible that it could happen and, if it did happen, then those who defended cost bearing on the basis of the rights-harm argument would be committed to this rather counter-intuitive conclusion.<sup>147</sup>

## 6.5 Justice and luck egalitarianism

A number of different theories of distributive justice can be relied upon to defend cost-bearing in relation to risky health affecting behaviour. A solidarity based argument for cost bearing has been mooted and other philosophers have argued that a defence of cost-bearing could be derived from a theory of justice based on the principle of fairness as reciprocity or on some kind of principle of restoration (Smart 1994; Wilkinson 1999; Brown 2009).<sup>148</sup> A defence of cost-bearing could also be mounted on the basis of “*communitarian, libertarian and contractualist*” approaches to justice (Schmidt 2009).<sup>149</sup>

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<sup>147</sup> This is not necessarily problematic but one imagines that most people – including most health care professionals and most policy makers – would balk at this possibility. If so their only recourse would be to reject the rights-harm argument as a whole. Personally, I would be reasonably happy to bite this particular bullet, but I realise that many would not.

<sup>148</sup> The solidarity based argument states that individuals have a duty to reciprocate with each other, a duty to ensure that they avoid placing excessive demands on each other and a limited duty to help each other out when there is a strong need. On the basis of this argument it has been suggested that society should “encourage” people to act responsible by adopting healthier lifestyles, finding productive work if they can and taking steps to avoid placing excessive demands on the healthcare system (Buyx 2008; Brown 2009). I would argue that some degree of cost-bearing could also be based on this principle in line with the idea that people who are morally responsible for their ill-health ought not to overly burden their fellow citizens and, thus, abuse the solidarity principle.

<sup>149</sup> Buyx (2008) argues that a communitarian account of justice could require individuals to contribute to the common good by being responsible and she goes on to argue that such an account “*could also*

However, in this section of the thesis I will concentrate on the theory of justice which is commonly referred to as “luck egalitarianism”.<sup>150</sup> I will stick to this particular theory of justice for three reasons. Firstly, luck egalitarianism has attracted support from a wide range of contemporary political philosophers and it is now one of the dominant theories of distributive justice (Kymlicka 2001). Secondly, many luck egalitarians have already suggested that the theory could defend claims of cost bearing in relation to health (Segall 2010). Thirdly, I find luck egalitarianism to be especially compelling and I think that it captures the essence of what is meant by distributive fairness.

Nonetheless, before I move to the analysis of the luck egalitarian defence of cost bearing I want to say a few words about another fairness-based defence of cost bearing which seem to lack a name in the literature but which I will call the “intuitive” or “common-sense” conception of distributive justice. It is worth spending a few moments discussing this “theory” of justice because a number of bioethicists as well as some health care professionals and patients seem to rely on this conception of justice to underpin cost bearing claims (Schmidt 2008).

The intuitive conception of distributive fairness simply states that in situations of resource scarcity it is unfair if people who are morally responsible for taking risks with their health (for no good reason) avoid cost bearing because this will deplete the

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*legitimises a public system that exerts pressure and withholds resources in cases where individuals do not comply”.*

<sup>150</sup> Some people prefer to use terms like “responsibility-sensitive egalitarianism” to describe what I will call luck egalitarianism.

resources available to other patients who are not morally responsible for their ill-health. Wikler (1987), for example, argues that *“those who risk illness by smoking, lack of exercise and other unhealthy habits are unfairly burdening their neighbours...Fairness demands then, that these costs be imposed on those who generate them...the person who takes risks with his own health gambles with resources which belong to others”*.

This particular approach to cost bearing differs from the luck egalitarian approach that I will discuss shortly because it only applies in situations of resource scarcity where people have taken risks “for no good reasons” and it relies on a fairly unsophisticated concept of justice. Interestingly, this account of fairness may underpin the “right-harm” theory that I discussed in the previous section. In other words, it is possible that the ultimate basis of the rights-harm argument is not the existence of a natural moral right to health but the intuitive conception of fairness which states that in situations of resource scarcity people who are morally responsible for needing extra resources must bear costs in order to avoid taking resources that somehow belong to others. This would imply that the language of rights is simply the gloss that is put on deeper claims about justice. If true, this would mean that a discussion about whether people have a positive moral right to health and whether people who are morally responsible have to bear costs can only be settled by an analysis of the concept of justice.<sup>151</sup>

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<sup>151</sup> Wolff (2012) argues that, in a practical sense, it is easier for philosophers and activists to lobby in favour of health policies on the basis of rights than on the basis of claims about justice because politicians and policy makers are more familiar with – and more afraid of – the concept of moral (and legal) rights and are thus more easily influenced by claims that certain policies will prevent rights-violations than by claims that certain policies will prevent injustices.

Given more space and time I would like to have explored and developed this intuitive conception of fairness in more detail and I would also have liked to delve further into the debate about whether the right-harm argument can be re-described as a debate about justice. However, I will now leave these issues aside and concentrate on the question of whether the more fully developed theory of distributive justice known as luck egalitarianism can be relied upon to defend cost bearing claims.

### **6.5.1 Luck egalitarianism: a brief overview**

Luck egalitarianism was first developed as a theory of justice over thirty years ago by Ronald Dworkin and since the publication of Dworkin's (1981a; 1981b) seminal articles on luck egalitarianism many philosophers have developed and defended their own version of this theory of justice (Temkin 1986; Arneson 1989; Cohen 1989; Roemer 1998). Perhaps unsurprisingly, there is much disagreement between these different luck egalitarians about how the theory should be defined and understood. However, most luck egalitarians subscribe to the following propositions: (i) equality is a core feature of justice, (ii) inequalities which are due to luck are unfair and (iii) inequalities which are due to people's choices are not unfair. Most, if not all, luck egalitarians also believe that the currency of justice should be allocated in such a way that the effects of bad luck are ameliorated (in so far as they can be) whilst the effects of choices for which people are responsible for should be left uncompensated – unless they are compensated for reasons that have nothing to do with justice (e.g. for reasons of charity).<sup>152</sup>

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<sup>152</sup> The currency of justice is variously described as resources, welfare, capabilities or "access to advantage".

Dworkin (2002) summed up the luck egalitarian position up by claiming that it would be unjust if people were to *‘lead their lives with less wealth available to them, or in otherwise less favourable circumstances...not through some choice or gamble...but through bad brute luck’*.<sup>153</sup> This is because Dworkin claims an unequal distribution of the currency of justice is only fair if it is “*endowment insensitive*” and “*ambition sensitive*” – i.e. only if reflects people’s choices rather than their circumstances. Fundamentally, then, luck egalitarianism reflects the common ethical intuition that people’s fate should not be determined by factors beyond their control and that they should bear some of the costs associated with the choices that they make (Kymlicka 2001).

At this point it should be obvious why so many supporters (and critics) of luck egalitarianism believe that this theory of justice can be deployed to defend cost bearing in relation to risky health affecting behaviour. This is because people who take risks with their health (and who are morally responsible for doing so) may be said to suffer from bad “option” luck whilst people who are not morally responsible for their ill-health may be said to suffer from bad brute luck (Cappelen and Norheim 2006; Buyx 2008). Consequently, it follows that people who are not responsible for their ill-health should be provided with health care resources to help ameliorate the bad luck that they have suffered, but people who are morally responsible for their ill-

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<sup>153</sup> Bad brute luck is defined by Dworkin (2002) as a “*matter of how risks fall out that are not in that sense deliberate gambles*”. Option luck, by contrast, is a “*matter of how deliberate and calculated gambles turn out – whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined*”.

health should bear their own costs because they have no justice-based claims to any publicly funded resources (Cappelen and Norheim 2005; Feiring 2008).<sup>154</sup>

In fact, one of luck egalitarianism fiercest proponents, Richard Arneson (1989), argues that it would be just to provide eyeglasses to patients who born with an eye condition but *“if a person became blind through deliberate and fully informed participation in a dangerous sport that often gives rise to injuries that result in blindness, it becomes questionable whether compensation is owed to him”*.<sup>155</sup>

In summary, then, the luck egalitarian argument as it applies to health care cost bearing can be summed up as follows:

1. Health inequalities that are due to (brute) luck are unjust and should be ameliorated if possible.

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<sup>154</sup> The provision of health care resources would not always return those who have suffered pure brute luck back to their pre-luck state. However, the provision of free health care would ameliorate some of the negative consequences of ill-health in most cases and, on occasion, health care would return the patient back to the state that was very similar to the one they were in before they suffered bad luck.

<sup>155</sup> Waltzer (1984) argues that the provision of different goods should be ruled by different principles of justice (because they belong to different “spheres of justice”) and he specifically argues that the provision of healthcare belongs in its own sphere of justice and should be governed by principles of solidarity, community, decency – rather than some luck egalitarian conception of justice. Interestingly, some luck egalitarians have agreed with this idea and they argue that although luck egalitarianism has its place the theory should not apply in the sphere of justice that deals with the distribution of health and health care. In fact, some believe that health is the sphere of justice *par excellence* where luck egalitarian theories should not apply (Segall 2010). I will not explore this argument in this thesis, because I do not think that there are “internal” luck egalitarian reasons to make this claim, but I accept that if we take into account different values this argument might undermine the luck egalitarian defence of cost bearing in relation to risky health affecting behaviour.

2. Health inequalities that people are morally responsible for (i.e. inequalities that are the result of option luck) are not unjust and should not be ameliorated on the grounds of justice.
3. The state has a right and a duty to ensure that claims of justice are met, but has no further duty in relation to other kinds of distributive claims (e.g. claims of charity).
4. *Therefore*, people who are morally responsible for their risky health affecting choices should bear the costs of their health affecting choices whilst those who are not morally responsible should not have to bear costs.

### **6.5.2 Brute and option luck and the demands of justice**

The first and second premise of the argument outlined above forms the core of the luck egalitarian thesis.<sup>156</sup> The first of these claims, which is sometimes called the “anti-luck” aspect of luck egalitarianism, runs counter to the right-libertarian claim that not all inequalities which are due to bad brute luck are unjust (Knight and Stemplowska 2011). Indeed, luck egalitarians of all stripes firmly believe that where people are not morally responsible for an inequality the inequality is arbitrary from the point of view of morality.<sup>157</sup> Moreover, they also think that this moral arbitrariness underpins both the claim that these kinds of inequalities are unjust and the claim that a

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<sup>156</sup> These premises can come apart from each other. Many non-luck egalitarians agree that inequalities that are due to brute luck are unjust (i.e. they accept the first premise of the argument) but reject the claim that inequalities due to luck are always just (i.e. they reject the second premise of the argument). However, though these propositions are logically distinct they can be combined and the unification of these claims (alongside the commitment to equality) is what makes luck egalitarian a distinct theory of egalitarian justice.

<sup>157</sup> Rawls (1971), who is sometimes regarded as the source of inspiration for the luck egalitarian theory, also argued that such inequalities were “*arbitrary from the moral point of view*”.

theory of distributive justice must seek to “neutralize” the impact of luck.<sup>158</sup> This means, in the health care context, that luck egalitarians believe that health care resources ought to be provided to those who suffer bad option luck (e.g. they are born with a genetic disease) if the bad option luck creates an inequality in a relevant currency of justice.

However, unlike many other egalitarians, luck egalitarians are also committed to the claim that inequalities that people are responsible for are not unjust and should not be ameliorated on the grounds of justice. This is sometimes called the “pro choice” aspect of luck egalitarianism and this claim runs counter to many other egalitarian theories of justice which state that at least some inequalities that people are morally responsible for should be compensated. The key luck egalitarian claim here is that it is not unfair for people to have more – or less – of the relevant currency of justice than anyone else if these inequalities are solely the result of choice for which people are morally responsible.<sup>159</sup>

In terms of health care, this means that “pure” luck egalitarians believe that people who are morally responsible for their own health have no claim of justice to any

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<sup>158</sup> Luck egalitarians recognise that it is not always possible to achieve this latter goal. For example, if someone is born with a fatal genetic disease for which there is no cure nothing much can be done to neutralize the effects of luck. However, in other cases it is possible to distribute social goods in such a way that those who suffer from bad brute luck can be compensated. For example, people born with congenital deafness could receive a free cochlear hearing aid and this will at least partially compensate for the bad luck that has occurred.

<sup>159</sup> Admittedly, Dworkin’s (2002) definition of option luck suggests that it is only “*deliberate and calculated gambles*” which lead to inequalities which are open to these claims. However, the concept of moral responsibility is broader than this and it seems that most luck egalitarians (including Dworkin) would agree that inequalities which are due to choices which are *not* gambles should also be regarded as inequalities which are not unjust. The key, in other words, is not whether people gamble, but whether they are morally responsible for their choices.



health care resources. Thus, unless people are willing to provide these resources as a matter of charity, those who are morally responsible will have to bear the costs of their own risky health affecting choices.

Philosophers from the right of the political spectrum generally argue that the second premise of the luck egalitarian argument is true but that the first premise is false. For example, right-libertarians argue that we need not ameliorate all inequalities that are due to brute luck in order to ensure that people are treated justly and as moral equals. As far as the right-libertarian is concerned, as long as our basic liberty rights are equally protected, people can suffer from bad brute luck (e.g. being born with a debilitating genetic disease) without having a claim of justice against other people to provide resources to help ameliorate their bad luck.

Philosophers from the left of the political spectrum, on the other hand, generally agree with the first premise of the argument but deny that the second premise is true.

“Social” or “democratic” egalitarians argue that the luck egalitarians’ failure to ameliorate (at least some) inequalities which are due to choice means that they do not treat people fairly or as moral equals (Anderson 1999). For example, a democratic egalitarian will argue that if a skier fractures her skull in an accident health resources must be provided to treat the skier even if she is entirely morally responsible for her injury.

Ideally, I would analyse both the right-wing and left-wing critiques of the luck egalitarian defence of cost bearing in this thesis, but because I lack the space to do so I will concentrate on the criticisms mounted by those who are on the left of the political spectrum. I will do so because it is “left wing” criticisms which strike at the

heart of the claim that luck egalitarians properly understand the value and meaning of the concept of equality.

Democratic egalitarians deny that the choice/luck distinction is normatively vital and they deny that this distinction always explains which inequalities are acceptable and which need to be neutralised. One key reason for this is because many egalitarian philosophers believe that people who are really committed to equality should care more about the issue of whether people can function as equals in society than the question of whether people are – or are not – morally responsible for their unequal share of the currency of justice. Anderson (1999) argues that it is irrelevant if people are unequal as a result of choice if the inequality undermines people's civil, social and political standing and she argues that people should be compensated to ensure that they can participate as equals in society even if they are morally responsible for not being able to do so.<sup>160</sup>

In response to this initial critique of luck egalitarianism, the first thing to note is that few democratic egalitarians will be wholly opposed to the idea that the choice/luck distinction ought to partially determine whether inequalities are unjust. In other words, there will be situations where most democratic egalitarians will not think that people should be compensated when their choices go awry. It is unlikely that a democratic egalitarian would wish to compensate a gambler who has lost a small amount of money and it is probable that they would not believe that a skier who has suffered a small and inconsequential laceration to his leg should receive health care as

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<sup>160</sup> In a similar vein, Daniels (2008) argues that too much emphasis on personal responsibility for health “ignores egalitarian considerations central to democratic equality [because] our health needs, however they arise, interfere with our ability to function as free and equal citizens”.

a matter of justice. This is because, in these situations, the outcome of the risky choices that people make does not affect these individuals ability to function as social equals.

The second thing to note is that although the democratic egalitarian's objection seems powerful when we consider people who engage in a small number of risky choices, the objection has less resonance when we consider people who make large numbers of risky choices. If a scuba diver takes a risk and suffers an injury that would undermine his ability to function as an equal in society it seems intuitively true that providing health care is just. However, if the same person scuba dives on a regular basis and takes serious risks every time he does so it seems counter-intuitive to claim that he must receive compensation (in the form of healthcare) every time he gets injured. The point is that, at some stage, most people's intuitions "flip" and they begin to think that "enough is enough". Part of the explanation for this has to do with the concept of moral hazard (i.e. if people know that if they take risks they will be compensated they are more likely to take risks), but I also think that it is because people consider it to be unjust to continue to compensate someone who is morally responsible for taking multiple risks.

The third thing to note is that the objection that luck egalitarianism will undermine people's ability to function as equals if they are made to bear costs relies on the idea that people will have to bear costs through some kind of denial of access to health care. The examples that Anderson (1999) herself uses – e.g. of the man left to haemorrhage to death on the side of a street once he has been deemed to be responsible for the road traffic accident that has caused his injury – implicitly assumes

that cost bearing must be cashed out as denial of access. However, I do not see why this must be the case. For example, luck egalitarians can require people to bear costs by paying extra taxes or by purchasing health insurance – in which case there will be no denial of benefit and people will not lose their ability to function as equals.

Another major critique of the luck egalitarian position is that luck egalitarianism fails to respect people as equals because it “insults” those who suffer from certain kinds of inequalities as a consequence of luck. It is claimed that because luck egalitarians wish to offer compensation to those who are congenitally deaf on the grounds that they are unlucky and unfortunate this means that they inevitably insult people by treating these deaf people with “*offensive pity*” (Knight and Stemplowska 2011). Anderson (1999) also argues that luck egalitarians are committed to officially informing certain people that they are disadvantaged even when they can function as equal citizens and she goes on to argue that this will fatally undermine people’s self-respect. Furthermore, Wolff (1998) claims that luck egalitarianism requires people to “*self-reveal*” themselves as disadvantaged through no fault of their own and this, he claims, is humiliating.

In response to these closely related set of objections I will begin by pointing out that democratic egalitarians are just as likely to see inequalities as disadvantages that need rectifying in some situations. If being born with congenital deafness undermines people’s ability to function as social equals, democratic egalitarians will themselves wish to identify this inequality as a disadvantage and would wish to ameliorate it, if possible, through the provision of health care resources. Moreover, they would have

to “officially” inform these people of their disadvantage too. As such, it is not quite clear why this approach is any less “insulting” than the luck egalitarian approach.

Admittedly, democratic egalitarians are likely to argue that the way in which such inequalities should be tackled is not through the allocation of more resources to those who are disadvantaged but by changing social attitudes so that people with these conditions can function effectively. However, luck egalitarians might be equally content with neutralizing the effects of luck in these situations in exactly the same way.

I would also argue that whether people really regard it as insulting to be compensated because of bad luck is not clear. Perhaps in today’s society this might be true, but if people begin to see the justice of the luck egalitarian account then fewer people would be concerned with revealing to themselves – and others – that they are not responsible for certain conditions and they would then cease to be humiliated or insulted by such revelations.

### **6.5.3 State interference in the name of justice**

I argued earlier that state intervention is easier to justify in the case of rights violations than it is in relation to the moralistic desert and expected consequences defence of cost bearing. This is because rights violations are an especially serious offence and the state has more solid grounds to interfere to prevent such violations from occurring than it does to protect autonomy or to penalise people who engage in allegedly immoral behaviour which only harms the person who engages in the

behaviour. In the case of luck egalitarianism I argue that state intervention is also much easier to justify than it is in the moralistic-desert and expected consequences account. This is because the purpose of state intervention where luck egalitarianism is concerned is to ensure that *justice* is done. The point being that claims of justice are, like rights claims, normatively very strong which means that if we accept that someone is owed something in the name of justice governments have a powerful *prima facie* right and duty to ensure that what is owed is provided.

In the context of the luck egalitarian argument this means that the state has a right and a duty to ensure that people who suffer from bad brute luck receive compensation whilst also ensuring that people who suffer from bad option luck do not receive compensation – at least not as a matter of state-enforced justice. Thus, the state must intervene to ensure that people who suffer from bad brute luck receive health care and the state has an obligation to ensure that people who suffer from (pure) option luck bear the health costs of their choices. This does not mean that the state must intervene *wherever* some form of unfairness occurs. However, where the claims of justice relate to something as vitally important as health and health care legitimate concerns about state interference ought to be trumped by the overriding need to ensure that justice is done.

Importantly, the luck egalitarian defence of state intervention is also easier to defend than state intervention in the name of autonomy or moralistic desert because there is no requirement in this case for the state to intervene to defend a certain conception of the good. Instead, the state is simply intervening to ensure that (distributive) justice is

done. In this sense the luck egalitarian shares with the right-harm argument a commitment to liberal neutrality.

#### **6.5.4 Luck egalitarianism: concluding thoughts**

The luck egalitarian conception of justice is not the only conception of justice in existence, but this particular theory does capture the essence of the meaning of fairness in relation to the distribution of goods and I think that we can only treat people as moral equals if we ensure that it is only the inequalities caused by “option”, rather than “brute”, luck that are compensated on the grounds of fairness. As such, this account of justice offers a very powerful defence of the claim that people who are morally responsible should bear the costs of their health affecting choices. This is not to say that the luck egalitarian position is invulnerable. Indeed, many powerful objections can be levelled at the luck egalitarian position from both the right and the left of the political spectrum. Nonetheless, I think that this particular conception of justice is correct and I also think that it provides the most powerful defence of cost bearing in relation to risky health affecting choices of all the arguments that I will discuss in this thesis.

Before I move onto the utilitarian argument, however, I wish to point out that the luck egalitarianism argument shares with the moralistic desert and the expected consequences arguments the feature that it would require people to bear health care costs even if resources were abundant. In other words, luck egalitarians are effectively “blind” to the availability of resources and cannot accommodate the claim that people should receive resources as a matter of justice even if there are plenty of resources

available for people suffering from bad brute and option luck. This is because the availability of resources does not affect the claim that people who suffer from bad option luck should not receive compensation in the name of justice.<sup>161</sup> Again, this is a very counter-intuitive and many people will believe that such an implication undermines the normative power of the argument. However, as ever, these intuitions may be wrong and, even if they are not, I think that the power of the luck egalitarian argument entails that we must bite this bullet too.

It is also important to recognise that luck egalitarians cannot distinguish between people who take different types of risks or who take risks for different reasons. Instead they are committed to the claim that everyone who is morally responsible for taking risks must bear costs (Fleurbaey 1995). As I have mentioned earlier, such a conclusion runs counter to most people's intuitions and many will regard this implication of the luck egalitarian argument as normatively untenable. However, as I have also argued above, it may be that most people's intuitions about this matter are wrong and given how compelling the luck egalitarian argument is, this is one bullet which I think we must bite.<sup>162</sup>

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<sup>161</sup> As it happens, luck egalitarians would have no objection if people suffering from bad option luck received these resources as a matter of charity (which is not true in the case of the moralistic desert and the expected consequences argument), but this does not change the fact that pure luck egalitarians would refuse to provide resources to people in the name of justice even if these resources were plentiful.

<sup>162</sup> Some luck egalitarians "escape" from this objection by arguing that luck egalitarianism is but one component of justice (and but one component of morality) and that it can be supplemented with other conceptions of justice (and other moral values) which then enable "intuitive" distinctions to be made (Segall 2010). However, from the "pure" luck egalitarian position such an escape route is not possible.



## 6.6 The utilitarian defence of cost-bearing

The last normative defence of cost bearing in relation to risky health affecting behaviour that I will discuss is an argument based on utilitarian principles. In effect, the utilitarian argument is a very simple one and can be summed up as follows: people should be made to bear the cost of some of their risky health affecting choices because this is the best way to maximise net utility.<sup>163</sup> However, though the essence of the argument is simple enough to state the argument rests on a number of contestable empirical and normative claims that need further exploration. The complete utilitarian defence of cost bearing runs as follows:

1. People can improve their health by modifying their health affecting behaviours.
2. People who are healthy have higher levels of utility than those who are not healthy.
3. Forcing people to bear some (non-marginal) amount of the costs of their health affecting choices will increase the probability that people will modify their health affecting behaviour in a way that will improve their health.
4. Forcing people to bear some (non-marginal) amount of the costs of their health affecting choices will lead to a net gain in utility.
5. Increasing net utility should be the ultimate goal of all actions.

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<sup>163</sup> The core of the utilitarianism itself may be summarised very simply: an act (or a rule) is good if it increases net utility and the best act (or rule) is the act (or rule) which maximises net utility. The theory is consequentialist in nature for it determines the moral worth of an action (or rule) by appeal to the consequences of the action rather than to its motive or nature. In this sense utilitarians regard acts (or rules) as only instrumentally, rather than intrinsically, immoral.

6. The state has the right and the duty to implement policies which increase net utility

7. *Therefore*, forcing people to bear the costs of their health-affecting choices is defensible on utilitarian grounds

I have argued extensively for the first premise of this argument in earlier chapters and I will not rehearse these arguments again here. Likewise, I will take it as read that the second premise is true.<sup>164</sup> However, the other premises of the argument are more controversial and I will now attempt to provide evidence for the empirical claims made in the third and fourth premise before moving on to discuss the normative claims made in the fifth and sixth premise.<sup>165</sup>

### 6.6.1 Enforcing cost bearing improves health

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<sup>164</sup> It may be possible to dispute the assertion that healthier people have higher levels of utility, but this does not seem like a promising rebuttal because people will generally experience greater levels of pleasure and happiness if they are healthier. Moreover, most people have a strong preference for being healthy and being healthy is usually regarded as a constituent part of any “objective” concept of the good. As such, it seems fairly obvious that, *ceteris paribus*, being healthy will lead to greater levels of utility than being unhealthy regardless of how we define utility.

<sup>165</sup> Utilitarians could also argue that people should be made to bear costs if they take some types of risks with their health because people who suffer from conditions caused by some types of risky behaviour have a worse prognosis than people who suffer from conditions not caused by risky behaviour. For example, Skarkey and Gillam (2010) argue that “*patients with self inflicted diseases (eg obesity-related diseases) should have lower priority in access to healthcare because they are more likely to experience poor medical outcomes*”. Such claims are usually based on the fact that people who suffer from conditions caused by risky behaviour (e.g. smoking and drinking alcohol) are more likely to continue to engaging in these risky behaviours after that have received treatment. This argument is often made in relation to liver transplants for people suffering alcoholic liver diseases. If true, then it makes sense to make these people bear costs because it ensures that limited resources are spent on patients where the treatment will be more effective.

*Prima facie* the claim that people will modify their behaviour if non-marginal costs are imposed on their choices may seem obvious. Standard economic theory would suggest that this is the case because, if we are rational agents, a non-marginal increase in the cost of a given action will inevitably influence our choices. Quite what counts as a non-marginal cost is not easy to decide, but no one is likely to deny that forcing people to pay some of the costs of their health-affecting choices will usually count regardless of the form that the cost takes.<sup>166</sup>

A number of commentators have specifically argued that implementing policies which force smokers to pay costs by denying them access to coronary bypass surgery will encourage smokers to give up their habit (Kass 1975; Sharkey and Gillam 2010). In a similar vein, Smart (1994) has argued that providing equal access to people who are and who are not responsible for their ill-health creates a perverse incentive and thus increases the number of people who take risks with their health. Denier (2005) also argues that a denial of access policy would “*scare a considerable number of people away from smoking, drinking, unsafe sexual activities and other forms of hazardous behaviour*”.

Furthermore, there is some empirical evidence to suggest that imposing non marginal costs does change people’s behaviour. In particular, there is considerable evidence to suggests that higher rates of tobacco taxation has led to a decrease in the number of people who smoke and the amount of tobacco that smokers consume. For example, the World Bank (2012) suggests that a price increase of 10% on a packet of cigarettes

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<sup>166</sup> The form that the cost takes will almost certainly affect the probability that the cost will have an impact on people’s behaviour.

reduces consumption by about 4%. Furthermore, modelling carried out Levy et al (2005) indicates that when tax increases by a factor of 10 (indexed to inflation) the smoking prevalence rate is likely to fall by 15% in the immediate aftermath of the increase and by 30% over the following decades. The evidence is now so strong that the US National Cancer Institute Expert Panel (1993) claims that “*a substantial increase in tobacco excise taxes may be the single most effective measure for decreasing tobacco consumption*”.

Admittedly, the evidence is not incontrovertible. Poorer people in the US tend to lack as much health insurance cover as their wealthier counterparts and yet the fact that they effectively face higher health costs if they fall ill – and sometimes have to forgo treatment altogether because they cannot afford to pay – does not seem to make them take fewer risks than their wealthier compatriots. In fact, smoking and many other forms of common risky behaviours, as I have noted in previous chapters, are much more common in lower socio-economic groups.

This suggests that the prospect of bearing higher costs does not modify people's behaviour and Harris (1995) argues that this is not surprising because: “*if the prospect of better health and a longer life on the one hand and fear of premature death from cancer or heart disease on the other does not act as an incentive, it is unlikely that the further fear of failure to get priority in medical care will add much to the incentives and disincentives already in place*”.

However, in the case of poorer people, it may well be that other factors are influencing their choices to continue smoking and taking risks – e.g. ignorance of the

degree of risk that they are taking and ignorance about the costs of health care – and if these other factors were nullified people in lower social groups might react rather differently. Moreover, though Harris’ point is an important one there is still plenty of evidence to suggest that enforcing costs (especially by placing taxes on dangerous products like tobacco and alcohol) does diminish the number of people who take certain kinds of risks. As such, there is sufficient reason to think that the third premise of utilitarian cost-bearing argument is true.

### **6.6.2 Enforced cost-bearing and net welfare**

In the previous section I have tried to establish that there is good evidence to believe that cost-bearing policies will reduce the probability that people will engage in risky health affecting behaviours. If this is true then it follows that implementing such policies will improve the overall level of health in society. Moreover, if we assume that increased health leads to increased welfare we now have a *prima facie* reason to think that cost bearing policies will improve people’s wellbeing.

However, to establish the truth of the fourth premise of the argument stated above – i.e. that enforcing cost bearing policies will lead to an increase in *net* utility – it will be necessary to take a wider perspective on these matters. This is because health is not the only variable which impacts on utility even if we define utility in an objective rather than a subjective way. As such, a careful analysis of all the ramifications that a

cost bearing policy might have needs to be made before we can claim that these policies can be defended on a utilitarian basis.<sup>167</sup>

There are a number of reasons why we might think that cost-bearing policies will improve utility. The first reason is the one that I have mentioned above: cost bearing policies will change health affecting behaviour for the better and the greater levels of health that this will engender will lead to greater levels of utility. But cost-bearing policies might also improve utility because they increase people's sense of autonomy (Waller 2005).

The claim that greater autonomy leads to greater utility is not especially controversial, but the further claim that the *enforcement* of cost-bearing policies will lead to greater levels of autonomy sounds paradoxical in the extreme. The natural assumption is that any enforcement of cost will, by definition, reduce people's range of options and, consequently, their autonomy. However, if we utilise a thicker concept of autonomy which takes into account second and third order preferences it is possible that we may be drawn to the opposite conclusions.

The key point here is that many people wish to remain healthy and many people have a second order desire to engage in positive health affecting behaviours and avoid risky health affecting behaviours. However, most people find it difficult to act on these preferences and desires because they are "overwhelmed" by first order desires. This is important, because if cost bearing policies enabled people to act on their higher order

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<sup>167</sup> I will not attempt to provide an exhaustive analysis of all the possible ramifications of all possible cost bearing policies here, but I will spend some time exploring some of the key ramifications and their likely impact on net utility.

preferences then it could be argued that such policies increase people's autonomy to act on their deep-seated preferences.

Needless to say, the notion that enforced cost-bearing policies would, in reality, enable people to act on their higher order preferences is controversial. However, this is not an entirely absurd claim and if it could be established that such policies did increase people's autonomy it might then be possible to infer that cost bearing policies not only increase utility by directly improving health but also increase utility by increasing people's ability to act on their higher order preferences.

Cost-bearing policies might also improve utility in an even more in-direct way. This is because these policies, in so far as they are effective in improving people's health, might free up health care resources that could be spent on improving utility in other ways. For example, these resources could be used to provide greater levels of paediatric health care or they could be used for other social purposes – such as providing better educational facilities, higher social security or more public parks – that almost everyone would benefit from. The underlying point is that providing health care resources to those who need them represents a major opportunity cost which means that there is real merit in the claim that utility could be enhanced if at least some of these resources could be used for other goals.

These kinds of considerations provide reasons to believe that cost-bearing policies increase people's welfare. But there are a number of reasons why these policies might decrease people's welfare too. The most obvious reason why this might occur is precisely because, whatever form the cost takes, the imposition of a cost is, *prima*

*facia*, bad.<sup>168</sup> Different health care cost bearing policies will engender different levels of harm. Financial costs, for example, would reduce the amount of resources people can spend on other goods, whilst denial of access to healthcare would leave some people in extreme pain.<sup>169</sup> However, all costs will dent utility to some extent whatever form the cost takes.<sup>170</sup>

Cost bearing policies might also cause a loss of utility because some people find responsibility itself hard to bear. There is some reason to believe that certain groups of patients prefer not to take decisions about their health care and other groups of patients – e.g. people who have a fatalistic approach to health – are less willing to take proactive steps to remain healthy. Moreover, many people experience the desire to place the “locus of control” for health somewhere beyond themselves and find it difficult to take responsibility for their own health. These factors matter because if utilitarians argue that cost bearing policies will encourage people to take greater responsibility for their actions and it is then found that many people find taking responsibility onerous, cost bearing policies will cause a great deal of distress and may, thus, decrease net utility.

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<sup>168</sup> Conceptually, this is what makes a cost a cost and gives the concept of a cost an inherent negative value.

<sup>169</sup> It is also important to bear in mind that the *fear* of having to pay costs (especially if these costs take the form of denial of treatment) may significantly decrease people’s welfare. Such indirect negative effects on human welfare may be hard to measure, but they need to be taken into account when balancing the effects of cost-bearing policies on people’s health.

<sup>170</sup> It may also be the case that the enforcement of certain cost bearing policies will lead to a “double” loss of utility because some people will simply “pay” the extra cost and continue to behave in exactly the same way as they did before the cost was forced upon them. For example, some people will continue to smoke exactly the same amount of cigarettes that they previously smoked even if tax duties were increased substantially. Thus, some people will suffer a double jeopardy because they will pay two costs (i.e. the tax cost and the cost of suffering from ill-health).



Against this, it might be said that taking steps to improve or maintain one's health is empowering. People may find the task daunting to begin with, but once they begin to take control of their own lives they will see the merit of doing so and this will become self-reinforcing. Some people, once they come to realise how powerful and effective a tool "taking" responsibility is, may even seize the opportunity to take control of their own lives and benefit considerably as a result. Pandering to people's weaknesses may not be the best way to improve people's health and wellbeing because challenging people to overcome their weakness may, in the long run, prove to be a far more effective way of improving health and wellbeing.

The adoption of cost bearing policies may also lead to a loss of utility for the indirect reason that an overemphasis on personal responsibility may prevent politicians, physicians and patients from focussing on the social and environmental causes of ill-health. Quite how big a risk is involved here is hard to determine, but the risk is almost certainly real. However, as I argued in the first chapter, there is no *necessary* link between placing an emphasis on personal responsibility for health policies and de-emphasising the role that socio-economic factors play in determining people's behaviour and health or visa versa. The concepts of social and personal responsibility for health are not mutually exclusive. Thus, although we need to be especially vigilant in order to ensure that we pay sufficient heed to personal and social factors there is no reason to think that we cannot achieve this goal.

In summary, I think it is reasonable to claim that cost bearing policies are likely to increase and decrease utility for different reasons and in different ways. The great difficulty lies in determining whether these policies are more likely to lead to a *net*

increase or decrease in utility. There is obviously no way of answering this question *a priori* even if we can predict that the more serious the cost the stronger the deterrent effect will be and the more suffering will be caused to those who must pay the cost. This means that a careful, policy by policy, empirical assessment is needed if a defence of cost bearing on utilitarian grounds is to be successfully grounded on this empirical claim. However, we have at least some reason to think that some forms of cost bearing policies might not only change people's behaviour but will also have a positive *net* effect on utility.

### **6.6.3 Increasing net welfare should be the ultimate goal of all moral action**

Utilitarianism is a normative theory with a long history. It is elegant and simple to understand and it also unquestionably captures some of our intuitions about what morality is about. In particular, it reflects the common belief that at least one constituent part of morality has something to do with increasing and, ideally, maximising utility. It is partly for these reasons and partly because the utilitarian theory is so easily applicable that utilitarian thinking has had such a strong hold over policy makers and politicians over the last century or so. Indeed, health care policy makers today, though they are also influenced by liberal egalitarian and libertarian theories of justice, are still very much influenced by utilitarian thinking. For example, one of the key quasi-governmental health organisations in the UK, the National Institute of Health and Clinical Excellence (NICE) partly assesses the value of medical treatments on the basis of a cost-effective analysis that is, at heart, utilitarian in nature (Herring 2010).

However, though utilitarianism has strong roots and is often used as the basis of policy making decisions in many branches of government many philosophers have come to reject utilitarianism as a basis moral and political philosophy. This is not the place or the time to venture into an in-depth discussion of the merits and demerits of utilitarianism as a normative thesis, but I will discuss one narrow critique of utilitarianism which is very germane to this thesis.

The objection that I will focus on has been mentioned already and it is this: the utilitarian defence of cost-bearing applies whether people are morally responsible for their health or not. To illustrate the point we can imagine utilitarian policy makers implementing a tax policy with the aim of decreasing risky behaviour in order to increase net health and net utility. Let us say that they succeed and that 20% of people respond in the way envisaged and that the remaining 80% do not change their behaviour. Let us further stipulate that 50% of those who don't change their behaviour could not have done so anyway (i.e. perhaps because they were completely addicted and would not stop even if the tax increase was much more substantial) and that 50% of those who do change their behaviour do so for reasons beyond their control (i.e. they change behaviour not because they consciously think about the options but because the tax policy works like a sub-conscious "nudge").

If this is how the policy works then it clearly will *not* be sensitive to moral responsibility considerations. Some people will end up bearing added costs even though they are not morally responsible (e.g. the addicted group) whilst others will avoid bearing costs even though their success in avoiding the cost had nothing to do

with any choice for which they can be moral responsible (i.e. those influenced by nudge factors). The question is: does this matter?

Utilitarians will argue that this does not matter because their sole concern is the maximisation of utility. However, anyone who believes that moral responsibility is a necessary condition for legitimate cost-bearing will deny that this is so. Indeed, it is worth reiterating that every other normative argument that I have analysed assumes that moral responsibility is necessary for cost bearing. This means that a very large number of philosophers will claim that there is something fundamentally wrong with the utilitarian approach to this matter.

On the other hand, we cannot simply stipulate that moral responsibility is necessary because utilitarians will rightly claim that this simply begs the question against them. Nevertheless, given the weight of opposition against the utilitarian claim the burden of proof probably lies on their shoulders and I must admit that I am not convinced that utilitarians can really offer a way of proving that it is normatively legitimate to hold people to account even if they are not morally responsible for their risky choices.<sup>171</sup>

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<sup>171</sup> One route around this problem would be for utilitarians to adopt a pluralistic position whereby people are required to bear costs if this increases net utility, but only if they are morally responsible too. In many ways I think this plural solution offer a very powerful argument in favour of cost-bearing and I think that many policy makers and lay people would support such a normative position. Nonetheless, I will not discuss this option any further here because as I stated at the beginning of the chapter I would avoid discussing normative defences of cost bearing which are based on multiple values.

#### **6.6.4 The state has the right and the duty to implement policies which maximise utility**

The last premise that needs to be established if the utilitarian argument is going to be successful in defending cost bearing is the claim that the state has the right and the duty to implement policies which maximise utility. Utilitarians can certainly argue that the state has this right and duty because the ultimate goal of morality, from the utilitarians' perspective, is to maximise utility and so, if state intervention is the best means to this goal, then state intervention is permissible.

However, many utilitarians concede that although the state has the right and duty to intervene in the name of utility, it should avoid doing so because state intervention will often lead to a decrease in *net* utility. One reason for this is because state intervention can cause much harm to other values (such as autonomy) which also contribute to utility. In fact, it is this kind of consideration which ultimately underwrites the harm argument that I discussed earlier in this chapter.<sup>172</sup>

Whether utilitarians would be willing to enforce cost bearing is, thus, a delicate matter and it entirely depends on what the overall impact of state interference would be on net utility. That John Stuart Mill (1998), one of the most eloquent defenders of utilitarianism, was so opposed to state intervention might incline us to think that although utilitarians can, in theory, defend state interference to maximise utility

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<sup>172</sup> It is also the case, of course, that non-utilitarians will deny that the state can interfere with people's lives in the name of utility because they deny the core utilitarian claim that the primary goal of morality is to maximise utility.

through the imposition of cost bearing policies, such an approach is not likely to be defensible in practice. However, we ought not to jump to this conclusion. In order to be sure a careful analysis of the effect that state interference in the form of enforced cost-bearing has on net utility is needed and it is possible that at least some forms of cost bearing (e.g. taxes on risky commodities) would not have a deleterious net effect. As such, we must at this time suspend judgment on this issue until further empirical work is carried out to determine how state interference via cost bearing affects net utility.

#### **6.6.5. Utilitarianism: concluding thoughts**

The utilitarian argument offers a powerful normative defence of cost-bearing in relation to risky health affecting behaviours. However, defending cost bearing on the basis of utilitarianism is not without its problems. In particular, this defence relies on empirical claims which are difficult to prove and which cannot yet be shown to be true because we lack adequate data. Additionally, this defence rests on normative claims about the value of utility and utility maximisation which many will deny. The pure utilitarian position also denies that moral responsibility is a necessary condition for consequential responsibility and many people will find this troubling because it means that some people will be made to suffer even though they were not morally responsible for their ill-health.

On the other hand, the utilitarian argument does have the added “intuitive” advantage that it would not *necessarily* require people to bear the costs of their choices if resources were abundant. If resources were abundant then the disutility of not

providing resources when they were easily available would probably outweigh any benefit derived from influencing people's behaviour. However, this too is an empirical claim that must be shown to be true and it may be that the disincentive effects remain powerful enough to defend cost bearing policies even when resources are available.

The utilitarian argument also offers some scope for distinguishing between different types of risky behaviour. In a *prima facie* sense the utilitarian argument is not committed to making any distinctions between different risk taking behaviours. However, it does not rule out the possibility of making of these distinctions either. This is because utilitarians are committed to adopting the policies which maximise utility and it may be that requiring cost bearing in every kind of case achieves this goal, but, equally, it may be that this is only true in relation to certain kinds of risk taking behaviour.

Indeed, I would argue that because certain risky health-affecting behaviours are instrumentally very valuable (i.e. they themselves help to increase utility) whilst others are not, utilitarians are likely to conclude that distinctions can be made. For example, fire fighting, falling pregnant and engaging in everyday risks are, in most cases, instrumentally valuable activities and so it is unlikely that utilitarians would want to disincentivise these kinds of behaviours through cost-bearing policies. Thus, although the utilitarian defence of cost bearing policies cannot distinguish between cases in an *a priori* fashion, it is almost certain that the utilitarian approach would closely mimic the distinctions made by the moralistic desert argument discussed

above and will, consequently, draw conclusions about who should (and who should not) bear costs which will be inline with most people's intuitions.

## 6.7 Convergence and divergence

In the introductory chapter and again at the beginning of this chapter I made reference to a number of “convergence” claims. One of these convergence claims was that the five normative arguments discussed above would converge to defend cost-bearing policies in relation to certain “core” groups of risky health affecting behaviours. I also noted that they would diverge in relation to another set of “non-core” cases. Now that I have analysed the five normative arguments in some detail I will highlight the types of cases where the five arguments converge to defend cost bearing and where they pull apart from each other. I will then briefly discuss these findings before bringing this chapter to a close and moving on to discuss cost bearing policy options in more depth.

The following table (Figure 6.0) describes all the risky health affecting behaviours that I identified in chapter four and details whether the five normative arguments that I have outlined in this chapter defend cost bearing in relation to these risky behaviours.<sup>173</sup> Where a check mark (✓) is present the claim being made is that cost bearing can be defended on the basis of a relevant normative argument. Where a cross (X) is present the claim being made is that cost bearing cannot be defended. Where a check mark and a cross (✓/X) co-exist, this indicates that whether cost bearing is

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<sup>173</sup> I have also added one more “behaviour” – or, rather, reason for behaviour – namely: “health risks taken for altruistic or socially valuable reasons”.



defensible or not is unclear – though the presence of a star next to a check mark (✓\*)

mark indicates that cost bearing is probably defensible and the presence of a star next to a cross (X\*) indicates that cost bearing is probably not defensible.

**Figure 6.0. Risky Behaviours and Normative Arguments.**

	<b>Desert</b>	<b>Expected Consequences</b>	<b>Rights-Harm</b>	<b>Luck egalitarianism</b>	<b>Utilitarianism</b>
<b>Smoking</b>	✓	✓* / X	✓	✓	✓* / X
<b>Alcohol</b>	✓	✓* / X	✓	✓	✓* / X
<b>Illicit Drugs</b>	✓	✓* / X	✓	✓	✓* / X
<b>Unhealthy Food</b>	✓	✓* / X	✓	✓	✓* / X
<b>Unprotected sex (aim = pregnancy)</b>	X	✓ / X*	✓	✓	✓ / X*
<b>Unprotected sex (aim ≠ pregnancy)</b>	✓	✓* / X	✓	✓	✓* / X
<b>Excessive UV light exposure</b>	✓	✓* / X	✓	✓	✓* / X
<b>Exercise &amp; Sports</b>	X	✓ / X*	✓	✓	✓ / X*
<b>Occupational hazards</b>	X	✓ / X*	✓	✓	✓ / X*
<b>Everyday risks</b>	X	✓ / X*	✓	✓	✓ / X*
<b>Preventative Health Care</b>	✓	✓* / X	✓	✓	✓* / X
<b>Post diagnosis behaviour</b>	✓	✓* / X	✓	✓	✓* / X
<b>Health risks taken for altruistic or socially valuable reasons</b>	X	✓ / X*	✓	✓	✓ / X*

As we can see from the table the rights-harm and luck egalitarian arguments (in their “pure” forms) defend cost bearing regardless of the type of risk being taken or the reason why the risk is being taken, whilst the moralistic desert argument only defends cost bearing in a limited number of “core” cases.<sup>174</sup> The expected consequences and utilitarian arguments are less clear cut but both could, in theory, make similar distinctions between core and non core cases.

## **6.8 Consequential responsibility: general conclusion**

In this chapter I have presented and analysed five normative arguments which may be used to defend the idea that some people who are morally and/or causally responsible for their health should be forced to bear some of the costs associated with their risky health affecting behaviour. I have also argued that these arguments converge to defend cost bearing in relation to certain “core” risky health affecting behaviours and that they diverge in relation to other “non-core” behaviours. Moreover, I have argued that the luck egalitarian offers the most defensible defence of cost bearing of all the arguments that I have analysed here.

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<sup>174</sup> The “core” cases that all five normative arguments (probably) converge around are the cases where people smoke, drink alcohol, use recreational drugs, consume too many “dangerous” food substances, expose themselves to UV light, have unprotected sex for reasons other than procreation, fail to engage in preventative health care and fail to modify their post-diagnosis behaviour.

## Chapter 7

### Cost Bearing Policies

*“We took risks, we knew we took them; things have come out against us, and therefore we have no cause for complaint.”*

– Robert Falcon Scott

#### 7.0 Cost bearing: a brief introduction

Thus far in this thesis I have argued that people can, to an extent, be causally and morally responsible for their ill-health and that there are a number of normative arguments which can be deployed to defend the idea that people should bear some portion of the costs associated with their risky health affecting choices.

My primary goals in this chapter will be threefold. Firstly, I will discuss how cost bearing might be operationalised in the real world.<sup>175</sup> In particular, I will discuss five main policy options that I will dub the “denial of access to health care”, “payment”, “reduced priority”, “risk tax” and “risk insurance” policies.<sup>176</sup> Secondly, I will argue that, of these five policies, the risk tax and risk insurance policies are the most practically feasible and normatively defensible. Thirdly, I will defend the convergence

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<sup>175</sup> In other words, I will outline and analyse a range of responsibility-sensitive health care policies which would ensure that people who are responsible for their health affecting behaviour bear some of the costs associated with their choices.

<sup>176</sup> This is not an exhaustive list of possible cost bearing policies. However, all five of these policies have been previously mooted by academics and they have all been implemented somewhere in the developed world. As such, I believe they deserve special attention. I will, however, mention another possible policy approach in the final chapter which has not previously been implemented.

claim that all five normative arguments discussed in the last chapter can be relied upon to defend the risk tax and risk insurance policy schemes.<sup>177</sup>

Importantly, I will not discuss any form of “meta” cost-bearing policy in this chapter. For example, I will not defend some kind of hybrid policy, such as a joint “risk tax” and “priority” policy and I will also largely refrain from analysing how the value of responsibility should be intertwined with other values such as need and cost-effectiveness. My rationale for avoiding these kinds of syntheses is simply that analysing cost bearing policies in isolation from each other – and in isolation from a more pluralist framework will help to avoid unnecessary confusion. Adopting this non hybrid, non pluralist approach will also allow me to more easily identify the strengths and weaknesses of each of the policies that I will discuss. I accept that my account of cost bearing policies will be of less immediate practical use as a result of taking such an approach, but I also think that this “purer” method will provide a useful and clear framework for policy makers who wish to integrate responsibility based cost-bearing policies into politically feasible health policies.

### **7.1 Denial of access to health care: the policy**

Perhaps the most obvious way of ensuring that people bear some health cost is to deny access to health care to anyone who develops an illness or an injury as a consequence of a health affecting behaviour for which they are fully causally and/or morally responsible (Veatch 1980; Wikler 1987; Morreim 1995). People who are partially causally and/or morally responsible, meanwhile, would receive free health

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<sup>177</sup> I will also spend some time explaining why this convergence claim is not true of the other policy options – i.e. why the other options cannot be defended by all five normative arguments.

care to cover that fraction of their ill-health that they were not responsible for but would be denied further access to health care and people who were not at all causally and/or morally responsible would be eligible for free health care to cover all their health needs.<sup>178</sup>

In practical terms the denial of access to health policies would be dependent on health care professionals making assessments of their patient's degree of causal and moral responsibility when they first make contact with them. More specifically, health care professionals would have to interview and examine their patients and then try to determine both the diagnosis, the cause of the diagnosis and the degree of causal and moral responsibility for the ill-health or injury that had been sustained. This policy would also require health care professionals to make similar judgments on an on-going basis to determine the extent to which people were causally and morally responsible for their post-diagnosis behaviour. For example, patients would have to be assessed regularly to determine whether they were complying with medication, attending appointments regularly and properly monitoring their health.

In some cases it would be possible to determine the existence and degree of moral responsibility in the first "screening" session quite easily. If the patient was an incompetent child, or if the patient was clearly suffering from a "pure" genetic disease, or if the patient had been injured whilst playing an extreme sport, it would be easy enough to determine the existence – and the degree – of causal and moral

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<sup>178</sup> In a similar vein it would also be possible to ensure that people who present with diseases or injuries for which they are *not* responsible, but who fail to attend appointments or adhere to treatment regimens, bear some kind of cost if their failure to maintain their health was something for which they were causally and/or morally responsible for.

responsibility. However, in many cases it would not be possible to come to any kind of definitive conclusion about the diagnosis, let alone the extent to which people might be causally and morally responsible, during the initial consultation (Harris 1995). As such, many consultations – and possibly quite a lot of investigations – would be needed before any firm conclusions could be drawn. In the interim period, treatment might well have to be provided to prevent progression of the disease as well as to treat any symptoms that might arise.<sup>179</sup>

In these kinds of situations if a patient was found to be causally and morally responsible at a later date access could be halted from this point forth but nothing could realistically be done about the earlier “illegitimate” access to health care. Technically, attempts could be made to return the patient back to the state they were in pre-diagnosis. Alternatively, payments could be demanded retrospectively for the healthcare that had already been provided. However, unless there was a deliberate attempt to mislead (i.e. unless patients knew they were causally responsible for a disease and/or morally responsible for taking the risk that caused the disease and had tried to hide this fact) this would be unfair and, in some cases, impossible because the bills might be too high for the patient to afford. Moreover, any attempt to return people back to their pre-illness state would be quite barbarous and, in some cases, impossible to achieve. As such, even under a denial of access approach some health care would have to be provided for free even for those who were entirely causally and morally responsible.

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<sup>179</sup> In emergency situations this would almost always be true.

### 7.1.1 Denial of access to health care: strengths and weaknesses

The denial of access approach has three main strengths. The first of these is the fact that the policy is simple to articulate and simple to understand. The second advantage is that the policy definitively ensures that people who ought to bear some of the avoidable costs of their health affecting choices actually do so – i.e. it is “responsibility-sensitive”. The third strength is that this policy seems to be *relatively* popular amongst health care professionals and lay people (Peters 2007).<sup>180</sup>

Nevertheless, the denial of access policy is also riddled with a number of practical and normative problems that fatally undermine this particular approach to cost bearing. I will not discuss all of the objections that can be levelled against this policy in this chapter. Nor will I argue that all the objections that I will discuss cannot be gainsaid. Indeed, I will suggest that some objections can be overcome relatively easily. However, I will describe and analyse a number of important and powerful objections to the denial of access policy here and I will argue that this approach to cost bearing is neither normatively acceptable nor practically viable.

The first objection that I wish to discuss is practical in nature and it relates to the fact that implementing a denial of access to health care would be very resource intensive. There are a number of reasons for this. In the first place health care professionals would have to receive extra training to ensure that they can accurately and reliably

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<sup>180</sup> The study carried out by Richards et al (2003) which I discussed in chapter 3 shows that some patients support the denial of health approach to cost bearing. Moreover, there are many reports in the literature of health care professionals denying treatment to smokers, obese patients and drug abusers on the grounds that these people are responsible for their own ill-health (Morreim 1995; Persaud 1995).

judge people's degree of causal and moral responsibility. Secondly, health care professionals would have to spend considerably longer with their patients in order to make informed decisions about their patient's degrees of responsibility and this would involve dedicating valuable and scarce resources to this task (Benjamin 1997; Martens 2001). Thirdly, health care professionals would need to be supported by a team of administrators and investigative specialist who would be tasked with collecting and corroborating background information which would need to be garnered and verified before a decision about cost bearing could be made. These three factors would make the policy both administratively burdensome and costly to operate (Wikler 1996; Daniels 2008). I will call this the "*costly resource objection*".

In response to this objection it might be argued that the cost of administering this policy might well be worth while from a normative point of view if we believe that it is vital to make people bear costs in this way. On a more practical note it may also be argued that the administrative costs might be balanced, or even outweighed, by the savings that would accrue from not providing health care to those who are deemed responsible for their ill-health. Whether this latter claim is true or not is not easy to determine. In order to be sure it would be necessary to evaluate the loss to the economy that would ensue when people who would otherwise have been able to work productively are unable to do so because their injuries and illness are not treated. Nonetheless, there is at least a possibility that the policy would be cost-effective and until we have further empirical data about this we need to suspend judgment rather than assume that the costs of operating the system would be so onerous that they would undermine this policy approach (Persuad 1995).



Another problem with the denial access approach may be dubbed the “*damage to doctor-patient relationship objection*”. Health care professionals and patients have long paid homage to the importance of the delicate and intimate relationship that often develops between a doctor and a patient (Glantz 2007). This relationship is often built up over years – although it can also form much more rapidly – and it is based on mutual respect and mutual trust. It is also an important relationship because the success of healthcare depends on this relationship working well.

The trouble is that the denial of access policy would require health care professionals to pass judgement on their patient’s degree of causal and moral responsibility and this aspect of the policy might threaten or entirely undermine the doctor-patient relationship (Ashley-Miller 1993; Garfield 1993; Sinclair et al 1993; Cappelen and Norheim 2005). Schmidt et al (2010), for example, argue that if doctors are assigned “*watchdog*” and “*policing*” roles this will harm the therapeutic relationship between doctors and patients and Gantz (2007) suggests that if doctors were responsible for withholding treatment from patients on the basis of responsibility considerations this would distort and irreparably damage the doctor-patient relationship.

The primary problem is that many patients would begin to distrust their doctors and would thus be less willing to reveal sensitive information that might be critical to their wellbeing. This is because patients would (rightly) fear that their doctor’s decision might lead to a denial of access to health care (McMaster 2000). Gantz (2007) for example, argues that smokers will begin to lie about their habit if they think that they may be denied care if they are honest and Morreim (1995) points out that the “*the patient who tells his physician the truth is a fool*” in these kinds of situations.

Moreover, once a denial of access policy was put in place doctors would soon begin to distrust their patients because they would be well aware that many patients would attempt to deceive them in order to avoid being judged and denied access to healthcare (Thornton 2009). This, in turn, would lead to a further breakdown in the relationship between health care professionals and patients and if this cycle of lies and distrust continued the policy might entirely undermine the doctor-patient relationship.<sup>181</sup>

The second problem is that patients might also begin to resent the “judgmental” role that health care professionals would be playing. At the moment patients see health care professionals as primarily concerned with their health and wellbeing, but under this policy health care professionals’ role would change and this might well undermine the doctor-patient relationship too.

Quite how extensive and disruptive these problems would turn out to be is hard to quantify. It is certainly possible that the end result would be a near total destruction of the doctor-patient relationship. However, the answer to this question very much turns on whether patients generally agreed with the rationale behind this cost bearing policy. If they did agree the impact might not be as damaging because patients would realise that the new role of the health care professional was not only important but legitimate (Brown 2005).

Having said as much, most patients – even those who largely agreed with the denial of access policy and agreed with the idea that health care professionals should judge

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<sup>181</sup> If doctors were placed under an obligation to report any deceit to a relevant authority this would undermine the relationship even further.

their patients – would probably not be willing to sacrifice their own health (and possibly their lives) by fully revealing their own “culpability”. Thus, it is rather likely that the much vaunted doctor-patient relationship would be badly damaged if a denial of access policy was put in place because the problem of distrust would remain.

From a practical point of view the policy might also run in to difficulties if health care professionals refused to take part in the system. A denial of access to health care policy would be very vulnerable to this kind of problem because it would rely so heavily on health care professionals’ judgments about their patient’s causal and moral responsibility and because some health care professionals would be deeply opposed to any policy which involved denying care to patients. Technically, health care professionals could prevent the implementation of the policy altogether if they took industrial action. However, they could also undermine the system by refusing to judge their patients, by colluding with their patients to change details about the likely aetiology of a disease, or by refusing to deny access to patients even when they knew that their patients were causally and morally responsible for their ill-health. I will call this the “*rejection by health care professionals’ objection*”.

It is an open question whether health care professionals would actually try to undermine the denial of access policy if it was put in place. It seems very likely that many health care professionals would be profoundly opposed to the policy because many of them feel strongly that they have a professional and moral duty to care for anyone who requires their help regardless of why they might need that help (Resnik 2007). Indeed, health care professionals are often in the vanguard when it comes to defending the rights of criminals, drug addicts, refugees, asylum seekers and other

minority groups' access to health care precisely because they think that health care should be available to everyone. Moreover, as we saw in chapter 3, a number of medical organisations, including the General Medical Council, are opposed to allowing considerations of responsibility to determine people's access to health care.

Morreim (1995) argues forcefully in this context that “*denying medical care for lifestyle vices conflicts with a deep moral conviction of medicine: compassion for the patient as a human being in need*” and he also suggests that most physicians would refuse to practice medicine if they were required to deny treatment to patients because this form of “*medical vigilantism*” would be repugnant to them. In a similar manner, Kelley (2005) argues that denying care would “*violate a valuable norm and an equally valuable virtue central to health care*” – i.e. the duty to treat those in need without regard to the provenance of their ill-health and the virtue of treating vulnerable people with compassion – and for this reason most health care professionals would refuse to comply with a denial of access policy.<sup>182</sup>

However, we should remember that health care professionals are not usually prone to civic disobedience and even when they disagree vehemently with a new policy they tend to acquiesce in the end.<sup>183</sup> Furthermore, we saw in chapter 3 that a relatively

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<sup>182</sup> Glantz (2007) is also quite adamant that “*one of the noblest things about the profession of medicine has been its single minded devotion to patients*” and he goes on to suggest that because the health care profession would be fatally undermined if patients were denied care on the basis of responsibility judgments most health care professionals would refuse to co-operate with such a policy.

<sup>183</sup> This point has recently been confirmed with the passage of the new Health and Social Care Bill (2012) in the UK. Health care professionals were – and still are – overwhelmingly opposed to some of the core legislative changes contained in the new Bill, but although many have voiced their disagreement during the process leading up to the creation of the Bill there is no sign that health care professionals will revolt now that the Bill has received Royal Assent.

substantial number of health care professionals seem to tolerate or even advocate denial of access to health care as a form of cost bearing for those patients who are causally and/or morally responsible for their own ill-health (Neuberger 1998; Ubel 2001).<sup>184</sup> Thus, although it is likely that some health care workers would refuse to co-operate if a denial of access system was put in place there is little solid evidence to prove that many would do so and it is quite possible that most professionals would simply get on with their jobs without trying to undermine the policy.

Yet another practical problem with the denial of access policy is the difficulty that health care professionals would face in trying to determining people's degree of causal and moral responsibility. Kelley (2005) argues that "*the causal trail to illness is so convoluted and complicated as to make causal grounds for responsibility*" extremely difficult for health care professionals to trace accurately and Harris (1995) makes a similar point about the difficulty that doctors would face in trying to determine people's degree of moral responsibility. Part of the problem in the latter case stems from the fact that it is difficult to determine whether patients are *culpably* ignorant (Benjamin 1997; Olsen 1997). Determining people's degree of freedom and their level of mental capacity would also be very difficult in many cases.

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<sup>184</sup> The history of the formation of the NHS is salutary here because many physicians were deeply opposed to the creation of the NHS because they feared that this would lead to the destruction of their lucrative private. It is also worth noting that in countries where patients must pay for their care out of pocket (or via private insurance schemes) physicians are often faced with patients who cannot afford the health care that they need because they don't have adequate insurance and do not have enough resources to pay for the treatment that they need. Yet, though some physicians offer these patients free or subsidised care, many more do not. In fact it may be argued that far from leading a revolution against such a system physicians seem to work hard to lobby governments in order to defend the system as it stands because the system as it stands partially protects their own financial interests.

In this context the argument is often made that attempting to determine people's degree of *legal* responsibility is a very difficult task which often requires judges and juries to carefully evaluate evidence for many days, weeks or months before coming to a decision about defendants' degrees of legal responsibility (Wikler 2002). Moreover, judges and juries can rely on a veritable army of police officers, lawyers and administrators to help them collect, organize and prepare the relevant evidence. Health care professionals would not have access to anything like this much assistance and they would have to make much quicker assessments and decisions – otherwise the system would ground to a halt. This would inevitably mean that the number of false positive and false negative judgments would be quite high (Aulisio 1996). I will call this the “*inaccuracy objection*”.

A similar objection relates to the need to ensure procedural justice. Following Aristotle (1984), most people agree that justice requires that like cases are treated alike. But it will be nigh on impossible to achieve this kind of procedural justice when thousands of health care professions are forced to make millions of “responsibility judgements” each year with little time or resources to check that they are all making judgments in the same way. This problem would be exacerbated because some health care professionals would, consciously or otherwise, be biased towards – or against – some patients. For example, some might be especially prejudiced against drug addicts whilst others would discriminate against the obese (Sharkey and Gillam 2010).<sup>185</sup> I will call this the “*unreliability objection*”.

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<sup>185</sup> Procedural justice also requires that some kind of appeal can be made in case patients feel that an erroneous judgment had been made (Wikler 2002). The obvious difficulty is that any appeal system would add considerable complexity and cost to the system and might not be practically feasible.

What can be said in response to the inaccuracy and unreliability objections? Training would certainly help to avoid both problems and providing health care professionals with more time to think about responsibility judgments would also help. The publication of guidance about how to make judgments would also assist matters and it might be possible to publish case material in journals to help physicians ensure that their judgments are in line with their peers. An appeals process could also be created. However, all of these interventions would be costly and, in reality, it would never be feasible to adopt all the various apparatus used by law courts to help ensure that justice is done. Thus, the inaccuracy and unreliability objections are both powerful and difficult to overcome.

The main normative objection which many have raised against the denial of access to health care approach is that the policy is cruel, harsh and inhumane (Morreim 1995; Wikler 1996, Flerubae 2002; Cappelen and Norheim 2005). There is, as Anderson (1999), argues, something deeply disturbing about the idea of paramedics arriving at the scene of an accident and leaving whoever was morally responsible for the accident to die on the side of the road.<sup>186</sup> In other words, abandoning patients to suffer and die just because they are causally and morally responsible is beyond the moral pale and no society should even contemplate adopting such a policy, never mind actually put it in to practice. I will call this the “*inhumanity objection*”.

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<sup>186</sup> Of course, few would argue that making snap judgments about responsibility at the scene of an accident – or even in the emergency department – would be a sound approach and so the dramatic sight of watching people bleed to death on the streets is unlikely to happen even if a denial of access policy is put in place. However, chronically ill people who were responsible for their ill-health would still be turned away from hospitals and clinics and acutely unwell would, in some cases, be required to leave their health care facility – even if this meant certain death – and so many other dramatic examples can be furnished to prove the point that these philosophers are trying to make.

This objection is especially powerful and many health care professionals, politicians and lay people are likely to reject this policy once they have fully taken onboard the inhumane implications of denying people access to health care. However, the normative arguments discussed in the previous chapters do provide us with some powerful reasons to make some people bear some of the costs of their health affecting choices and if we accept any of these arguments then we will have at least a *prima facie* reason to think that even a very harsh policy may be legitimate. Indeed, people are often led by their principles to defend capital punishment and judicial torture even though they also readily concede that these practises are inhumane. Thus, we cannot simply argue that, because a policy is inhumane, it is not justified.

Nevertheless, the sheer brutality of this policy does mean that even the very strongest of the normative arguments in favour of cost bearing (i.e. the luck egalitarian argument) does not give us sufficient reason to conclude that the policy is worth the suffering that it will engender. This is especially true given that there are alternative – and less inhumane – ways of making people bear some of the costs of their health affecting choices and given that these alternative methods are also compatible with the normative arguments discussed in the last chapter. As such, I think we have excellent reason to reject the denial of access policy on the basis of the inhumanity objection.

In addition to being inhumane, the denial of access policy also runs the risk of dehumanising health care professionals and the whole of society. The worry is that if health care professionals are required to effectively let “irresponsible” patients suffer



and die some of them will become inured to their patients' suffering and will become dehumanised as a result. Moreover, if society as a whole tolerates such policies, non-health care professionals may also become immune to the suffering of others and if this happens the dehumanising process will be even more problematic (Wikler 2002). I will call this the "*dehumanising objection*".

This objection, though similar to the inhumanity objection, differs from it because it relies on an empirical claim that adopting an inhumane policy will lead health care professionals and society at large down a slippery slope. In response, I argue that the denial of access policy does not *require* health care professionals or the general public to feel any degree of satisfaction when patients are denied care. Indeed, the denial of access policy may be regarded as a "terrible tragedy" and a "necessary evil". As such, the slope may not prove to be as slippery as one might at first imagine.

There is always the risk that health care professionals and others will become immune to the suffering of a given group and that this attitude will then spread more widely.<sup>187</sup> However, the evidential basis for this slippery slope argument is weak and I am not convinced that we have sufficient reason to think that this particular objection holds much water.

The denial of access approach is also vulnerable to the charge that such a policy would be extremely intrusive (Anderson 1999; Denier 2005). Moreover, as Dietrich (2002) argues, such a policy might also lead to "*massive breaches of citizen's privacy*

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<sup>187</sup> As we have seen in previous chapters, some health care professionals and members of the public have already adopted a fairly intolerant attitude towards drug addicts, alcoholics, smokers and the obese.

*rights*” and would cause irreparable harm as a consequence. The degree of intrusion into people’s private lives would be considerable. Questions would need to be asked about people’s behaviour and personal habits and it would be entirely possible that patients – and even their family, friends and employers – would have to be cross-examined in order to ensure that the judgments made were accurate (Daniels 2008). I will call this the “*intrusiveness objection*”.

Many philosophers regard this objection as a major stumbling block to a denial of access policy but, as Wolff (1998) argues, governmental agencies will always have to collect, process, and store personal information about people in order to make judgments about what kind of resources they are owed or need. For example, in order to determine people’s right to welfare payments governments will have to ask many intrusive questions (and store the responses in some kind of government database) and this is true even if the government is not trying to determine people’s degree of responsibility in anyway.

On the other hand, the nature of the personal information that must be collected in the case of the denial of access policy may be especially personal and because questions will be asked about personal responsibility for health in particular these questions may be experienced as especially intrusive. However, Wolff’s counterargument does take some of the sting out of the intrusiveness objection. Furthermore, patients might not regard the intrusion as particularly burdensome if they believed that the questions were necessary to establish a just health policy. Thus, the more people who agree with at least one of the normative defences of cost bearing the less intolerable the intrusion will appear to be.

The types of questions that would need to be asked to establish causal and moral responsibility would not just be intrusive. They might also be disrespectful because they would lead to what Wolff (1998) calls “*shameful revelation*”. If people are required to reveal certain kinds of personal information they might find this process embarrassing, disrespectful and shameful. For example, if people have to admit to errors of judgment in relation to risky behaviour they might feel embarrassed about having to do so (Daniels 2008). Likewise, if people have to ‘*make out a convincing case that they are a failure*’ in order to receive treatment they are likely to feel ashamed (Wolff 1998). I will call this the “*disrespect objection*”.

In response it may be argued that if people accept the normative rationale for cost bearing they may not experience any shame. If people accept the underlying concept of diminished moral responsibility they might not care about explaining that they are not entirely responsible for their actions. A greater willingness to be open about the forces that affect us might even prove beneficial because it would stop us from feeling shame about things that we cannot control. It is not clear whether this would, in fact, happen. However, shame is clearly tied to social expectations and if social expectations changed so might the existence and pervasiveness of this emotion.

The denial of access policy is also vulnerable to what I will call the “*proportionate health care objection*”. The problem is that providing strictly proportionate access to health care (e.g. providing 50% of treatment for people are deemed to be 50% morally responsible for their risky health affecting choices) will often not be workable because health care often needs to be provided as a package if it is to be successful at all. For example, if a patient is injured in a motorcycle accident and sustains a brain

haemorrhage and a ruptured spleen, it would be a complete waste of time and resources to treat the former injury whilst ignoring the latter.

In some cases the provision of some portion of a medical regimen will actually do more harm than good. The treatment of Tuberculosis, for example, often necessitates the provision of 4 different antibiotics for many months. Providing 50% of the antibiotics will not cure the disease in the majority of patients and will make things worse for many patients because some will develop side effects to the drugs and others will develop a pathogen which is resistant to antibiotics.

Carrying out the letter of the denial of access policy will thus lead to an injustice in some cases because it would be unfair to provide people with health care which is known to be ineffective or potentially dangerous given that their lack of full moral responsibility entails that they should receive at least some effective access to healthcare.

In response, it is worth pointing out that some illnesses and injuries can be treated reasonably effectively by using a “partial no-treatment” regimen. However, I accept that this is not always the case and that in many situations denying a proportion of treatment will often be self-defeating or dangerous. Moreover, because the adoption of this cost bearing policy will lead to these kinds of injustices the policy faces a real problem because it means that it cannot be fully supported by any of the normative arguments discussed in the last chapter.

The denial access policy would also be open to what I will call the “*changing the goal posts objection*”. The point is that if a government were suddenly to deny access to health care they would treat people unfairly because this would involve “*changing the rules after the game has begun*” (Persaud 1995). If people generally understood that healthcare would be provided to them regardless of whether they engaged in risky behaviours it would be unjust to suddenly inform them that this was no longer true. This would be especially true for those individuals who had paid their fair share of taxes and for those who had taken risks on the basis that free health care would be made available to them if the risks turned sour.

This objection is an important one. However, it can be overcome quite easily. All governments need to do to side step the objection is to give their citizens fair warning that such a policy was going to be imposed. This would then enable people to change their behaviour in light of this information if they wished to do so. The only difficulty would be that people might have to be given many years of warning and this would prevent policy makers from implementing a denial of access policy that would have an immediate impact. Not everyone would worry about this, but utilitarians, in particular, would likely argue that this would be a waste of time given that they would want to decrease the negative impact of risky behaviour as soon as possible.

The last objection to the denial of access to health care policy that I wish to discuss relates to the problem of luck. If we adopt the denial of access to healthcare policy then not everyone who is equally morally responsible for taking the same risk will experience the same outcome or be treated in the same way. This is because some will be lucky and others will be unlucky (Cappelen, Norheim and Tungodden 2008).

For example, if two people decide to sky-dive together and one of them breaks a leg on landing because of a sudden and unexpected gust of wind whilst the other lands safely, the factor that determines the different outcome in these cases is *not* the choice to engage in the risky behaviour but the unexpected gust of wind – and this factor is not something that either skydiver can be morally responsible for. Likewise, if fifty smokers smoke fifty cigarettes a day for fifty years some will develop lung cancer, some will develop some other smoking-related disease and some will not be adversely affected at all. Moreover, as with the sky diving case, the differences in outcome in these cases will be explained by a number of factors that people cannot be morally responsible for (e.g. genetic susceptibility to tobacco).<sup>188</sup>

To borrow the language of the luck egalitarians, the differences in these cases are due to a form of brute luck (Dietrich 2002; Cappelen and Norheim 2005; Feiring 2005). Grand (1991) finds this aspect of the denial of access policy deeply problematic because he argues that any normatively viable health policy must ensure that people who are equally morally responsible for taking equal risks – and not merely those who actually incur health costs – should bear costs of their risky health affecting choices. Cappelen, Norheim and Tungodden (2008) agree and they argue that the denial of access policy should be rejected for this reason. I will call this the “*luck objection*”.

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<sup>188</sup> Some factors that explain differences in outcome will be factors that people can be morally responsible for. People might, for example, engage in other protective behaviours such as regular screening and regular exercise in order to decrease the risks that they take. However, I will ignore this complication here.

The first response to this objection is to point out that the denial of access policy could be modified to take account of this problem. For example, health care professionals could deliberately inflict injuries or illnesses on people who were equally morally responsible for taking similar risks so that they too could be made to bear the cost of their ill-health by being denied access to healthcare. However, although this modification of the policy would solve the luck objection, it would also be very problematic for a number of reasons.

Firstly, such a policy would be extremely inhumane and would almost certainly be rejected out of hand by policy makers and health care professionals alike. Secondly, this policy would not always work because in some cases it would be difficult to inflict the kinds of injuries – and especially the kind of illnesses – that would need to be inflicted in order to create equalities of outcome. For example, it is not at all clear how type 2 diabetes could be induced artificially. Thirdly, it would be very difficult to set the “tariff” correctly. Smoking, as we have seen, causes a myriad of different conditions, but would this imply that all smokers would have to have all these conditions inflicted upon them in order to equalise the outcome? This might seem absurd, but it is hard to see how the “tariff” could be set another way. For these reasons, adopting this particular policy modification is not viable and so the denial of access policy cannot overcome the luck objection by adopting this kind of approach.

The second response is to argue that the luck objection is not an objection at all. The argument in this case is that the objection is not valid because the problem of “moral luck” – and the particular problem of “resultant moral luck” – is not really problematic (Nagel 1979). The relevant aspect of the moral luck issue is this: we

sometimes make people bear the full costs of their choices even though they are not fully causally or morally responsible for the consequences of those choices and we regularly treat different people who are equally morally responsible for taking a risk in different ways (e.g. we only make one group pay costs) even though the outcomes are partially determined by factors which people are not morally responsible for.<sup>189</sup> Many people think this is unfair, yet this is how the law (and society) often operates.<sup>190</sup>

Of all the normative theorists who have grappled with this issue it is fair to say that it luck egalitarians have done so most thoroughly. The standard luck egalitarian position, as it was developed by Dworkin (1981) and Cohen (1989), is clear enough: inequality created by bad option luck is not a matter for justice because option luck is something for which people are morally responsible. In other words, it does not matter if two people who are equally morally responsible for taking risks with their health end up with different health outcomes even if the reason for the difference is beyond the control of those who take the risks. However, a number of luck egalitarians and other commentators have questioned this assumption (Christiano 1999; Lippert-Ramussen 2001; Otuska 2002). The reason for this is because option luck is not, ultimately, “pure” in the sense that the original luck egalitarians seem to have believed. This is because if two individuals voluntarily take the same risk (i.e.

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<sup>189</sup> For example, we treat murderers and attempted murderers differently even if the only reason why the attempted murder failed to kill is because he was thwarted by a factor he could not control (Williams 1982).

<sup>190</sup> With regard to risky health affecting behaviour this issue matters because if we think that it is unfair to treat people differently in these situations then we will be forced to conclude that the luck objection is real and serious but if we deny that moral luck is problematic then the objection can simply be ignored.



take a risk in the option luck sense) the outcome of the risk is partly a matter of *brute* luck.

No luck egalitarian denies that there is a key difference between people who suffer pure brute luck (e.g. children who suffer from genetic conditions like Cystic Fibrosis) and those who suffer from a mixture of option and brute luck (e.g. the unlucky skydiver described previously). People who suffer pure brute luck are not even marginally morally responsible for the luck that affects them whereas those who suffer a mix of option and brute luck are morally responsible to some degree.

However, given that those who suffer option luck are also affected, in part, by brute luck a dilemma is created – especially for luck egalitarians because these philosophers are, *prima facie*, committed to regarding instances of inequality-inducing brute luck as unjust and they are also committed to neutralising the effects of brute luck when it creates such inequalities (Segall 2010). This raises the possibility that luck egalitarians – and, potentially other philosophers concerned with the impacts of luck on outcomes – are committed to neutralising the effects of brute luck even when it is option luck that has created the potential for brute luck to intervene.

Luck egalitarians divide over this issue. Cappelen, Norheim and Tungodden (2006), for example, argue that luck egalitarians should seek to ensure that people are held responsible for their choices rather than the consequences of their choices because the consequences of choices are partially determined by brute luck even when the choice

itself is not.<sup>191</sup> Segall (2010), on the other hand, argues that this approach misinterprets the spirit of luck egalitarianism. He suggests that luck egalitarians should not think of themselves as committed to neutralising the effects of all luck which create inequalities. Instead, they should be committed to holding people responsible for their choices. The key distinction, from the luck egalitarian point of view, should be between people who choose to engage in risky behaviour and those who do not. As Segall (Ibid, p 180) says, “*luck is indeed arbitrary...but tempting luck, as it were, is not...and what we owe each other, according to luck egalitarians, extends to neutralising luck only in the cases in which it has not been tempted*”.

One reason to favour the latter approach is that the former approach seems to justify redistributing money between gamblers once the result of the gamble is known. If a group of people place bets on a single game of roulette then the “luckist” luck egalitarian seems committed to saying that the inequality that results is partly unjust because brute luck partly determines the outcome. This would imply that fairness requires some redistribution of the winner’s winnings between all the players in order to neutralise the effects of brute luck. This, however, seems like a *reductio ad absurdum* because such a reallocation of resources not only defeats the purpose of gambling, but it also runs counter to our intuitions regarding fairness because the difference in outcome between two gamblers does not seem *prima facie* unjust.<sup>192</sup>

Lippert-Ramussen (2001) responds by arguing that there is a critical difference between “gambling proper” and “quasi gambling” – the latter being the type of gamble one takes when one takes risks with one’s health. He points out that the thrill

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<sup>191</sup> Cappelen and Norheim (2005) suggest that “*individuals who make the same choices should also have the same outcome*”.

<sup>192</sup> Gamblers would probably react to such claims of unfairness with bemusement.

of taking a risk is intrinsic to gambling proper, but is not to quasi gambling. When we take risks with out health, for example, we do not do so for the sake of the risk, but rather because we value something else (e.g. the pleasure we might derive from tasting rich French food). Hence, we should not treat the two cases alike.

Of course, some people who engage in extreme sports do so because they want to take risks. However, this only seems true of a limited range of risky health affecting behaviours. In most cases, people who take risks with their health – e.g. by smoking or eating too many calories or sunbathing excessively – would rather not take a risk at all if this was possible.

As such, luck egalitarians ought to be committed, in almost all cases, to eliminating the effects of brute luck wherever brute luck creates an inequality. Thus, some kind of redistribution between people who take risks with their health for reasons other than they want to gamble with their health is needed when bad brute luck strikes and creates inequalities between groups of people who are equally morally responsible for taking risks with their health. Indeed, luck egalitarians should accept that the costs of rectifying injustice should be shared between all those who take the same health risks since this avoids creating an unjust burden on those who did not take risks (e.g. those suffering from pure brute luck) whilst also ensuring that everyone who is morally responsible for taking the same risks is treated in the same way. This means that luck egalitarians, in my opinion, should be opposed to a denial of access policy because this policy does not treat those who are equally morally responsible for their own risky behaviour in the same way.

It is often not possible to create perfect equality in outcome between those who take the same risks. We can only do this in the case of risky behaviour by inflicting injuries and illnesses on people. However this is, as I have argued above, barbaric and, in many cases, impossible to achieve for practical reasons. However, some forms of cost bearing (e.g. risk taxes) would allow pooling of costs and could also be humane and I shall explore this possibility later in this chapter.

What about those who defend an alternative approach to cost bearing? Are they more or less likely to have a problem with the luck objection than luck egalitarians? Those who defend a moralistic desert approach would probably find the luck objection genuinely problematic. This is because they think that people who take certain kind of risks commit intrinsically immoral acts that are worthy of being penalised for retributive reasons. Given this fact, it seems likely that those who defend this approach would not want people who are equally morally responsible for engaging in equally immoral acts to be treated in different ways.

The expected consequences approach, meanwhile, seems to ignore the issue of moral luck entirely. The expected consequences approach states that people should experience the expected outcomes of their risky health affecting choices because doing so protects the value of autonomy. On the assumption that ill-health is an expected outcome and that denial of access to health care is also an expected outcome those who defend this argument have no reason object to the way that luck impacts on people's outcomes – at least not from “within” the expected consequences approach.

The rights-harm argument is neutral with regard to this particular issue. The rights-harm argument claims that people who are morally responsible for taking risks with their health must bear some of the costs if they fall ill otherwise they will consume resources from the common pool and violate other people's right to healthcare. However, whether people who defend this argument would also think that the costs should be shared between people who are morally responsible for the same risks entirely depends on their *independent* beliefs about moral luck. In other words, it is possible to defend the rights-harm argument and defend the idea that the burden should be shared, but it is also possible to defend the rights-harm argument and defend the idea that the burden should not be shared.

From the utilitarian perspective questions of luck and justice are not germane unless they impact on utility. Since many people are concerned about fairness and do worry about the impact of luck on just allocations of resources it is possible to argue that a utilitarian defence of cost bearing would need to take this into account. On the other hand, many people do not seem to regard moral luck as a problem at all and would not regard the luck objection as a valid objection. As such, it is not at all clear whether someone who wishes to maximise utility should object to the denial of access to healthcare policy on the basis of the luck objection. The answer ultimately depends on how many people find the luck objection valid and how deeply affected they are by the perceived injustice that occurs with brute luck intervenes in cases of option luck – but we lack the data to be sure one way or another.

In summary, whether people will think that the luck objection counts as an objection against the denial of access policy will depend on a number of factors. In particular, it

will depend on what people think about the problem of moral luck – but it will also depend on which normative rationale people use to defend cost bearing policies.

Personally, I think that the objection is both valid and serious. This is because I think that the “luckist” version of luck egalitarianism argument – i.e. the version which states that people who are equally morally responsible for the same risk should share as much of the cost as possible – is the version of luck egalitarianism which best captures the true meaning of distributive justice. But, for those who adopt a different normative approach, the objection may not have much bite.

### **7.1.2 Denial of access to health care: summary**

To summarise, the denial of access to health care policy has the following three advantages: simplicity, sensitivity to responsibility and support from reasonably large sections of the health care profession and the populace. It also, however, suffers from a number of objections including the very powerful “inhumanity”, “luck” and “damage to doctor-patient relationship” objections. Indeed, such is the range and power of the objections that can be levelled at the denial of access to healthcare approach that this particular form of cost bearing is not normatively viable or practically feasible. As such, policy makers should avoid trying to make people bear costs using this approach and individual health care professionals and health care managers should immediately stop denying health care to patients on the grounds that some of their patients are causally and/or morally responsible for their health.

## 7.2 Payment: the policy

The next cost bearing policy option that I wish to consider is the payment policy option. This policy requires people to bear the costs of their choices by paying the financial costs of the healthcare that they need at the point that they need it (Wikler 2002; Cappelen and Norheim 2006). In practical terms the payment system would work much like the denial of access to health approach. In other words, the system would be reliant on health care professionals carefully assessing their patients – with the help of administrative and investigative assistants – in order to determine the diagnosis, the cause of the diagnosis and the patient’s degree of causal and moral responsibility for their ill-health. As the with the denial of access approach the payment approach would also, in most cases, allow patients to be receive free health care in the first instance whilst relevant investigations were carried out.

Once the investigations were complete patients deemed fully causally and/or morally responsible would have to pay for any further health care whilst patients deemed not responsible would receive free health care. Patients deemed partially responsible would receive a certain amount of health care for free and they would then have to provide a co-payment if they wished to be provided with more care. The amount that these latter patients would have to pay would vary and the goal would be to charge costs which would be “*proportional*” to their degree of causal and/or moral responsibility (Cappelen, Norheim and Tungoden 2008).

### **7.2.1 Payment: strengths and weaknesses**

The payment policy, like the denial of access policy, has the advantage that it is simple to understand, “responsibility sensitive” and reasonably popular. Admittedly, few of the surveys conducted thus far have asked patients, professionals or the general public whether financial payments of this kind are their favoured cost bearing policy. However, there is some evidence to suggest that many people would support such a policy – even in countries like the UK where “out of pocket payments” for health services is relatively rare.

In Germany, citizens who fail to attend screening appointments are already expected to pay extra costs for any health services that they require if they develop diseases that could have detected if they had attended screening (Schmidt 2009c). Extra payments are also charged when people fail to attend appointments and people who require treatment to deal with problems following plastic surgery and tattooing are expected to cover the entire cost of any treatment that they might need. Importantly, these policies do not seem to be opposed by a majority of the German population – or by a majority of the German health care professionals – which suggests some level of tacit agreement with such a “payment” approach.

Even British citizens and health care professionals seem to tolerate a payment system within the NHS. For example, payments for dental care are routine within the NHS service and many patients also pay a small fee (currently £7.65) when they purchase prescription medications (Persaud 1995; National Association of Citizens Advice Bureaux 2005; Department of Health 2011).



Patients can also now “top-up” their care by purchasing medications which are not available on the NHS either because NICE has deemed the drug not to be cost-effective or because primary care trusts are unwilling to provide the drug for free for other reasons. This suggests that the British public tolerate some forms of payment for healthcare within an NHS framework, although there is less evidence that they would tolerate these payments if they were tied to consideration of responsibility (Robinson 2002).

*Prima facie*, the payment policy also has a number of advantages over the denial of access to health care approach. In the first instance, it is less vulnerable to the “inhumanity” objection that so fatally undermines the denial of access approach. The payment approach is less inhumane because people will be required to bear costs by providing financial payments rather than by being denied access to health care. This means that fewer people will be forced to suffer and die prematurely than would be the case if the denial of access policy was put in place.

The payment policy can only avoid the inhumanity objection entirely if everyone who has to pay for their health care can afford to do so. This, however, is unrealistic and this lack of realism creates a dilemma for those who wish to defend this policy because they must decide whether people who are unable to pay should be denied access to the health care that they cannot afford or whether they should be provided with the health care that they need free of charge.

The first of these solutions suffers from the obvious defect that it no longer fully avoids the inhumanity objection that caused such problems for the denial of access

approach. This is because, if this solution is adopted, plenty of people will suffer unnecessarily. It is important to note that the total number of people who would lack access to the health care would be much less than it would have been if a denial of access policy had been adopted. Likewise, the fact that the *goal* in this case would not be denial of access may also speak in favour of the approach. However, given that health care is often very expensive, a great many people would continue to suffer and die prematurely if this solution to the dilemma was chosen and thus the inhumanity objection would still loom very large.

The second option avoids the inhumanity objection altogether, but it violates the normative goal of requiring people to bear the costs of their choices when they are causally and/or morally responsible for their risky choices. In other words, adopting this approach would mean that the policy would no longer be entirely responsibility-sensitive. It would also create two further problems.

Firstly, it would be open to claims of injustice because people who took the same risks would be treated differently on the basis of their ability to pay. Secondly, it would create a situation of moral hazard. This is because the adoption of this approach would create an incentive for poorer people to take greater risks with their health and it would provide an incentive for richer people to divest themselves of their wealth if they fell ill as a result of their risky health affecting choices.

Obviously, if the money people owned was entirely a result of behaviours for which they were morally responsible the first objection would not arise. However, the reality is that differences in income and wealth are only partially the result of choices for

which people are morally responsible (Persaud 1995). Thus, the first objection remains a powerful one. The moral hazard objection, meanwhile, seems a little speculative, but I think that in some cases people would respond to these perverse incentives in exactly this kind of way.

Leaving these issues aside, I would also argue that the payment approach is less vulnerable to the “dehumanising” objection than the denial of access policy. The dehumanising objection, it will be remembered, claims that adopting a policy which is itself inhumane will lead to a situation whereby society and health care professionals adopt a more callous attitude towards suffering. The reason why the payment approach is less vulnerable to this objection is precisely because the policy is less inhumane than the denial of access approach. In other words, the policy is further up the slippery slope than the denial of access policy.

Of course, it is still possible that the slope would prove to be too slippery and it could be argued that the adoption of the payment approach would be the first step towards the adoption of a denial of access approach which would then lead to even more dehumanising. However, this may not happen and the fact that the goal of the payment approach is *not* to make people bear costs through denial of care might well help to prevent such an eventuality.

Since the payment policy is less inhumane it is less vulnerable to the “rejection by health care professional’s objection” than the denial of access policy too. This is because fewer health care professionals will be opposed to a policy which does not overtly aim at denying health care and which does not cause as much suffering as the

denial of access policy. Indeed, in the United States the health system which currently operates means that many people lack access to full health care because they cannot afford to pay for it and yet this state of play is largely tolerated by health care professionals and the general public alike.

The payment policy is also less vulnerable to the “proportionate health care objection”. This is because at least some patients would be able to afford to pay top-up fees or co-payments to cover the health care that they needed but were not provided with for free. For these patients, concerns about the provision of partial treatment where partial treatment would be either ineffective or counter-productive would simply not arise.<sup>193</sup> However, because some patients would not be able to afford the co-payment the objection still affects the payment policy.

The payment policy is also just as vulnerable as the denial of access policy to the “resource cost objection”, the “disrespect objection”, the “intrusiveness objection”, the “damage to doctor-patient relationship objection”, the “changing the goalposts objection”, the “unreliability objection”, “inaccuracy objection” and the “luck” objection. This is largely because this policy, like the denial of access policy, requires individual health care professionals to make judgments about their individual patients.

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<sup>193</sup> In cases where partial treatment would be partially effective, partial treatment could be provided for free (e.g. aspirin and nitrates in the coronary artery disease example discussed above) and the patient could simply forgo the rest of the treatment rather than pay a co-payment to access other “extra” medications. Adopting such a policy necessarily means that some people would get worse treatment than they might otherwise get, but it also ensures that people bear some of the cost by foregoing extra treatment.

Thus, although the payment policy undeniably has some advantages over the denial of access approach, it cannot be said that this policy successfully avoids any of the more serious objections which can be levelled at the denial of access policy.

### **7.2.2 Payment: summary**

I have argued above that the payment approach does have some advantages over the denial of access approach, although, in many cases, the solutions on offer are only partial ones. I have also argued that the policy is as vulnerable to many of the more serious objections as the denial of access policy. Consequently, I suggest that policy makers who wish to ensure that people bear costs should shy away from this form of cost bearing because it simply does not offer enough advantages over the denial of access approach to justify its imposition.

### **7.3 Reduced priority: the policy**

The numerous defects that afflict the denial of access and payment policies suggest the need for an entirely different cost-bearing approach. One such approach which has previously been discussed by academics and put into practice by health care professionals is what I will call the “reduced priority” policy (Wikler 1987; Moss and Siegler 1991; Harris 1995).

This policy ensures that people bear some kind of health cost as a consequence of their health affecting choices by varying people’s degree of priority for health care on the basis of responsibility judgments (Peters 2007). People who are not causally

and/or morally responsible would be given access to health care first, those fully causally and/or morally responsible would receive health care last and those who were partially causally and/or morally responsible would be placed somewhere in between – with their exact position determined by their precise degree of causal and/or moral responsibility.

In practical terms this policy would, once again, be similar to the denial of access policy in that it would require individual health care professionals to make judgments about their patient's causal and moral responsibility. Initial access to health care would also have to be provided before priority was determined because degrees of causal and moral responsibility would need to be assessed before a priority system was initiated.

However, this approach would differ in practical terms from the previous policies because doctors would not only have to make judgments about their patient's degree of causal and moral responsibility, they would also have to make comparisons between different individuals in order that people could be ranked against each other.

Under the denial of access and payment policies no such comparison between individuals would be necessary; people's degree of moral responsibility would be judged and then people would either be denied access or costs would be imposed.

However, if we adopted a priority approach people's degree of causal and/or moral responsibility would need to be judged *and* ranked after some kind of comparison had been made.

### 7.3.1 Reduced priority: advantages and disadvantages

As with the policies discussed one of the key advantages of this policy, other than the fact that it is simple to understand and is responsibility-sensitive, is the fact that it seems to attract fairly widespread support. Many health care professionals and bioethicists have defended this kind of responsibility-based cost bearing solution in relation to the specific question of how organs which are available for transplantation should be allocated. In particular, it has been suggested that people who require liver transplants because of alcohol abuse should receive lower priority than people who require liver transplants because of a genetic or metabolic disease (McMaster 2000). It may also be recalled from chapter 3 that a number of studies have shown that both health care professionals and the lay public tend to want to give people who are responsible for their health needs lower priority than people who are not responsible (Neuberger et al 1998; Ubel et al 1999).

Admittedly, the popularity of a reduced priority approach seems to be primarily centred on organ transplants rather than any other aspect of health care. However, waiting lists for appointments, investigations and treatment are ubiquitous in most countries and there is no *prima facie* reason why people who would support a responsibility-related reduced priority system in relation to organ transplants would not be equally happy with a responsibility-related reduced priority system in relation to health care more generally. In fact, it makes little sense to defend cost bearing via reduced priority in relation to organs but not in relation to other forms of health care.

In addition to being responsibility-sensitive and relatively popular the priority approach also has one key advantage over both the denial of access and the payment approaches discussed above. The advantage is that the priority approach is much less vulnerable to the inhumanity objection than either of these policies. This is because, although patients will have to wait longer to get the health care they need under the reduced priority approach, they will not be denied access outright or denied access if they cannot afford to pay.

This does not mean that the reduced priority policy is not vulnerable to the inhumanity objection at all. Indeed, there are many reasons to think that this is not the case. Firstly, people who are given a lower priority for accessing various forms of health care will have to wait a certain amount of time before they get the health care that they need. During this time they will, in many cases, continue to be symptomatic and, as a result, they will continue to suffer when they need not otherwise have done so. Secondly, diseases tend to progress over time. This means that patients placed lower down a priority list would not only tend to suffer more than they otherwise would have done but the effectiveness of the treatment that they will eventually receive will be decreased because it is harder to treat diseases which are more entrenched. Thirdly, some diseases, if they are not treated promptly, will render any treatment provided later entirely ineffective.<sup>194</sup> Delaying treatment for severe haemorrhage by a few minutes, for example, will usually be lethal.<sup>195</sup>

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<sup>194</sup> This is not always the case: delaying knee surgery for arthritis may lead to more suffering, but it will not adversely affect the outcome of the operation. However, in many instances a delay can be fatal.

<sup>195</sup> Likewise, delaying treatment for bowel cancer by a few months may well render whatever treatment is given later entirely useless – especially if the cancer metastasises in the mean time.



This means that, in some cases, the priority approach will have similar consequences to the denial of access and the payment approaches. However, the priority account is still not as vulnerable to the inhumanity objection as either of these other policies. To begin with, if resources are scarce people will be forced to wait for access to health care even if considerations of responsibility play no part in determining the system of priority.

This counter argument will only go so far, however, because there would be less suffering, less development of disease and less risk of people waiting for so long that treatment becomes ineffective if factors like need and urgency determined the order of priority alone. As such, the priority approach is less humane than other priority policies which do not take responsibility into account even though it is an improvement on the denial of access and payment policies.

The priority approach is also less vulnerable to the inhumanity objection than the denial of access approach – but not the payment approach – because there is a clear difference in intention between these policies. The aim of the priority approach is to make people bear some of the costs of their health care by placing them lower down a priority list. This is very different to the denial of access approach where the intention is to make people bear the costs of their choices by denying them access to health care. Those who defend the priority approach can hope that everyone will, eventually, get the health care that they need and they effectively defend a cost bearing system which does not (in theory) exclude this possibility. In fact, their policy is designed precisely to prevent people getting access to health care. The consequences of being placed on a waiting list will sometimes amount to a denial of access because some

people will wait too long to receive the treatment that they need. But this is not the goal of the policy.

The reduced priority approach also has the advantage that it is less vulnerable to the dehumanising objection than either the denial of access or the payment approach. The reason for this is because the reduced priority approach is even higher up the slippery slope than these other policies. This is because, as I have argued above, the priority approach is more humane than either of the other policies and so the probability that adopting this policy will lead to a situation where society and health care professionals become desensitised to suffering is less. Indeed, the risk of this happening if a reduced priority approach is adopted is very slim. This is partly because the goal in the case of the reduced priority approach is to provide health resources not to deny access, but it is also because some kind of priority approach is inevitable if resources are scarce and many non-responsibility based priority policies have already been put in place without any sign of doctors being dehumanised as a consequence.

Nonetheless, the policy is not without its problems. To begin with, it is just as vulnerable as the denial of access and payment policies to the distrust, resource-cost, rejection by health care professional's, inaccuracy, unreliability, intrusiveness, changing the goal posts, disrespect and luck objections. What is more, the priority approach is also vulnerable to another problem which does not affect either the denial of access or the payment policies.

The problem is that the priority approach not only requires people's degree of causal and moral responsibility to be assessed it also requires comparisons between people. This is necessary because people need to be ranked if this system is to work – but this can only be done if different people's degree of responsibility can be compared. I will call this the “*comparison objection*”.

The comparison objection is problematic because it raises two major issues. Firstly, it adds another layer of complexity to the cost bearing policy and secondly there is a serious ambiguity about who should be compared.

There are three main potential comparison groups: “people with the same disease”, “people who require the same type of health care” and “every patient”. The first option requires everyone with the same form of ill-health to be classified together and then compared as a group. For example, every type 2 diabetic's degree of causal and/or moral responsibility could be determined and then every diabetic could be placed on a waiting list, in order of responsibility, to await access to further health care.

The second option would involve classifying and comparing people who required the same type of health care. This is the kind of comparison which occurs when people are currently allocated to organ transplant waiting lists. Under a responsibility sensitive allocation, everyone requiring a specific organ (e.g. a kidney) would be compared and ranked against everyone else who needed the same organ even if they were suffering from very different diseases (e.g. diabetic nephropathy and polycystic kidney disease). The same kind of process could also happen for other treatments or

investigations – e.g. all those needing a CT scan of the head could be compared and ranked according to their respective degrees of responsibility.

The third option would require every single patient to be compared with every other patient. In this case, no account would be taken of disease or the actual health care needed. Rather, everyone would be assessed and would have to wait their turn to access whatever health care they needed on the basis of their overall degree of causal and/or moral responsibility. For example, a patient with lung cancer would be compared with everyone else – including patients with cardiovascular disease, occupational injuries and syphilis – and their position on some kind of “overall” waiting list would then be determined.

None of these options are without their difficulties. The first option is problematic because different patients will need different types of health care. For example, some patients with coronary artery disease need bypass operations and others need angioplasty operations and it is hard to see how the waiting lists for each treatment (which are always separate in practice) could be fused. However, if they were not joined in some way this would create an inequity because people with the same degree of causal and/or moral responsibility would wait different length of time because they happen to need different treatments.

The second option is also vulnerable to this objection because different patients with the same degree of causal and/or moral responsibility will end up being treated more (or less) quickly depending on what kind of healthcare need they have. For example,

if one patient needs a very scarce organ but another needs a relatively abundant organ then these patients will get access to the healthcare they need at different speeds.

The third solution would side step these problems, but this option is not feasible because it is not clear how different people with very different conditions could be properly compared. How, for example, do we compare the causal and/or moral responsibility of a smoker with the causal and/or moral responsibility of an obese patient? More importantly, far too many comparisons would have to be made to make the system workable.

### **7.3.2 Reduced priority: summary**

In summary, the gains made over the denial of access and payment policies by the reduced priority approach – namely the lower vulnerability to the inhumanity and dehumanising objections – are somewhat lost by the added complexity of the lower priority approach and the difficulty that is created by the comparison objection. Thus, although I think the priority approach might have a role to play in some situations – e.g. as a “tie breaker” when people with different degrees of moral responsibility need the same scarce health care resource – I am not convinced that this is the best possible responsibility-sensitive “cost bearing” that can be constructed.

### **7.4 Risk taxes and risk insurance: the policies**

In this section I will discuss the “risk tax” and “risk insurance” policies together. I will do this because the policies are very similar and because they share almost

exactly the same strengths and weaknesses. Indeed, the policies are so alike that the decision about which of these policies should be implemented depends on whether a country has a strong history of funding health care through taxation (e.g. the UK) or through social and private insurance schemes (e.g. Germany and the USA). In the former case I would advocate the risk tax policy and in the latter cases I would advocate the risk insurance policy.

The risk tax scheme would operate as follows. Policy makers, in conjunction with health care professionals, would devise a list of behaviours that they deemed to be causally associated with ill-health. They would then attempt to estimate the cost of providing health care for people who engage in these kinds of behaviours. Once this cost had been estimated governments would then tax the relevant behaviours. The revenue raised would then be earmarked to pay for any health care required by those who developed an illness after engaging in a risky behaviour (Cappelen and Norheim 2005). The tax rates would vary from behaviour to behaviour but each tax would need to be levied at a level “*sufficient to generate enough revenue to finance the extra treatment cost*” (Grand 1991). Moreover, no one would be allowed to engage in these risky behaviours unless they paid the relevant tax.

If policy makers wanted to ensure that people’s exact degree of moral responsibility was taken into account it would be necessary to modify the tax policy as follows. After the tax rate had been assessed and the tax had been put into place, people who wanted to engage in some kind of risky behaviour but who did not think that they were fully morally responsible for their choices would have to be offered a “moral responsibility assessment”. This assessment would be carried out by specialists – who

need not be health care professionals – and the goal would be to determine people's degree of moral responsibility for their choices.

Anyone who was deemed not to be fully morally responsible would then be entitled to a special tax discount. This could be operationalized by issuing everyone with a special "tax card" which would state how much tax people had to pay. Under this system, anyone deemed not morally responsible for their choices would not have to pay any tax at all whilst anyone deemed fully morally responsible would have to pay the full rate of tax. Those deemed partially morally responsible would have to pay a partial tax with the degree of tax tailored to their degree of moral responsibility.

In reality, people who wanted to take part in extreme sports or people who wanted to sunbathe excessively or people who wanted to have unprotected sexual intercourse would not likely avail themselves of this option because they would almost certainly be deemed to be fully morally responsible for their risky choices. However, people who want to smoke, drink alcohol excessively, or take drugs would be wise to ask for a responsibility assessment because, as we have seen, their likelihood of being fully morally responsible for these behavioural choices is not very high. As such, it is likely that they would be eligible for some kind of tax discount.

The risk insurance scheme would operate in a similar fashion. However, in this instance it would be social insurance companies, working under the auspices of governments, who would draw up the list of risky health affecting behaviours and work out the expected costs associated with these behaviours. Once these costs had been calculated insurance companies would then offer risk insurance policies to

anyone who wished to engage in any given risky health affecting behaviour. As with the tax system, the insurance premium would be determined by the expected cost of providing healthcare to those who developed an illness or injury after engaging in the risky behaviour in question. Moreover, the insurance premiums would have to be earmarked to cover the costs of the diseases caused by the behaviour that was being insured against. Finally, people would be prohibited from partaking in risky health affecting behaviours unless they had acquired the relevant health insurance cover.

Once again, if some account of people's degree of moral responsibility needed to be taken into account the risk insurance scheme could be modified so that people would be eligible to have their moral responsibility assessed. Those deemed fully morally responsible would have to pay the full premium, whilst those deemed partially responsible would receive a discount. Those not at all morally responsible would have their premium waived entirely.

#### **7.4.1 Risk tax and risk insurance: advantages and disadvantages**

The risk tax and the risk insurance schemes are both responsibility-sensitive cost bearing schemes and, like the other policies discussed above, there is evidence of considerable support for some kind of risk tax or risk insurance policy amongst policy makers, health care professionals and a number of governments (Veatch 1980; Leichter 1981; Wikler 2002). Surveys also suggest that there is significant support for these kinds of policies amongst the lay-public too. For example, a recent American study found that 53% of respondents believed it would be "fair" to require people who



engage in risky health affecting behaviours to pay higher insurance premiums (Civanar & Arda 2008).

It is also worth reflecting on the fact that tobacco and alcohol, in particular, have been taxed for centuries without much resistance. The rationale for taxing these products has always been multifaceted, but part of the modern purpose is to ensure that people who smoke and drink pay the costs of their own choices and few people seem to take umbrage at this idea (Morreim 1995; Cappelen and Norheim 2005).

A number of policy makers and academics have also recently defended the idea that risk taxes could be placed on products containing high levels of sugar, salt and saturated fat and some countries have already implemented such policies. For example, as I noted earlier, Denmark has placed taxes on products containing high levels of saturated fat and Hungary has done the same with a whole range of “unhealthy foods” (BBC News 2011).

Risk insurance schemes also seem to have attracted some support from governments, academics and the lay-public. The German government already allows “social” health insurance companies to charge higher premiums to those who engage in more risky behaviours and in America many private insurance firms require employees to pay higher premiums if they smoke or if they are obese. The state of Israel, meanwhile, does not allow scuba diving companies to rent scuba equipment unless divers can prove that they have taken out specific diving insurance (Israeli Diving Federation 2012).

Even in countries where specific health insurance exists, the idea that governments have the right to force people to buy insurance if they wish to take risks is still fairly novel and it is unclear how popular such an approach would be.<sup>196</sup> However, given the inherent similarity between this approach and the tax policy I think that a risk policy approach would garner a reasonable amount of support from professionals, patients and the lay public even if the insurance was mandatory. Moreover, under the terms of the Patient Protection and Affordable Care Act (2010) American citizens will effectively be “forced” to buy general health insurance and although this new law has divided opinion, many Americans seem to support this “mandatory” insurance policy.

In addition to being reasonably popular the risk tax and risk insurance policies also have a large number of advantages over all the other policies that I have discussed in this chapter. Indeed, both of these policies completely side-step the rejection by health care professionals objection, the damage to doctor-patient relationship objection, the inhumanity objection, the dehumanising objection and the changing the goalposts objection.

These policies would avoid the inhumanity objection entirely because everyone will continue to receive the health care that they need even if they are morally responsible for taking risks with their own health. This is because people who take risks will pay an insurance premium or a risk tax *before* they take the risk. Interestingly, Cappelen and Norheim (2005) argue that “*the tax burden imposed on each person ex ante (at the point of choice) could be considered as in-humanitarian if it imposes and*

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<sup>196</sup> Israel’s scuba diving policy seems to be the exception to the rule here.

*extremely high cost*". However, this is a bit of a stretch; an expensive tax or insurance premium is many things, but "in-humanitarian" it surely is not.<sup>197</sup>

These policies also avoid the damage to doctor patient relationship objection for the simple reason that health care professionals would not have to assess individual patient's degrees of moral responsibility under these kinds of schemes (Cappelen and Norheim 2005). This is because decisions about responsibility would be carried out "responsibility assessors" who were not trained health care professionals. Thus, although patients might distrust these assessors and dislike being judged by them, this would not impact on their relationship with health care professionals and so the doctor-patient relationship would not be adversely affected.

Since health care professionals would not have to sit in judgement over their patients and since these policies would not be inhumane health care professionals would also be much less likely to revolt against the imposition of these kinds of health care policies. Thus, both the tax and insurance policies neatly avoid the rejection by health care professional's objection too. Indeed, many health care professionals openly advocate stiff increases in tax on both cigarettes and alcohol and some also favour extending "risk taxes" to other unhealthy products and behaviours.<sup>198</sup>

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<sup>197</sup> Since these policies are not in any obvious way inhumane they also completely avoid the dehumanising objection.

<sup>198</sup> The tax and risk policies are not vulnerable to the changing the goalposts objection either because taxes and risk insurance payments could not realistically be applied retrospectively. They are, in other words, inherently "forward looking".

These policies also partially avoid the “luck objection”. This is because the risk tax and risk insurance schemes pool the resources of those who take similar risks and thus ensure that everyone who takes the same risk share some of the costs when the risks turns sour for some but not for others. Neither policy actually achieves the goal of ensuring that people who take the same risks experience exactly the same costs. This is because the “unlucky” risk takers will experience some form of ill-health or injury whilst the “lucky” risk takers will not. Nonetheless, the tax and insurance policies do ensure that some of the cost is shared and thus they help to avoid the “double injustice” that would occur if unlucky risk takers not only had to suffer ill-health but also pay had to pay for their health care whilst lucky risk takers avoided both costs.

However, though the tax and insurance approaches clearly have a number of advantages over the other policies they are not without their problems either. To begin with they are both still vulnerable to the costly-resources, intrusiveness, inaccuracy and unreliability objection. This is because responsibility assessments would still have to take place under this scheme and, although responsibility assessments would now be carried out by “responsibility assessors” rather than doctors, this process would still be expensive, it would still require assessors to ask intrusive questions and there would still be a risk of inaccurate and unreliable judgments being made.

Nonetheless, fewer responsibility assessments would need to take place under these schemes because many people (e.g. sky divers) would realise that there is little point asking for a responsibility assessments – and so the costs of operating the scheme would not be as substantial as would be the case if the other policies were put in place. Arguably, responsibility judgments would also be more accurate and less

unreliable because they would be carried out by “responsibility specialists” rather than health care professionals.

The risk tax and the risk insurance policies would also be vulnerable to a number of objections that do not affect the other policies that I have discussed above. One difficulty relates to the fact that tax and insurance policies must calculate tax and insurance premium rates on the basis of future health care costs. This, however, is very hard to achieve because the amount of money needed to manage diseases is not static. There are many reasons for this, but the primary problem is that scientific developments are constantly occurring and it is hard to pre-judge how expensive new products will be when they released onto the market (Wikler 2002). I will call this the “*prediction of costs objection*”.

One way around this problem would be to set the tax rates or the insurance premiums at a higher level than the current expected costs. If the costs were later found to be less than had been predicted then rebates could be provided to those who had overpaid. The difficulty with this solution is that many people would end up receiving a tax or insurance rebate when they were too ill to make use of the money. Given that neither situation is ideal I would opt to set the tax and insurance rate at a higher level than expected and then provide rebates as soon as it becomes clear that the extra money was not needed. This is not an especially neat solution, but given the difficulties with predicting costs I think it is the best available option.

The tax and risk policies are also open to the objection that these policies *force* people who engage in health affecting behaviour to pay the costs of the health care that they

might one day need. There are, in other words, no “opt outs” from either the taxation or the insurance schemes as I have described them. Thus, people would not be given the choice to decide not to pay a risk tax or the choice not to take out risk insurance if they wanted to take a risk with their health. This is arguably more of a problem for the risk insurance scheme because insurance is usually optional whilst taxes are mandatory. However, the underlying problem is the same: forcing people to take out insurance or to pay risk taxes in an unacceptable violation of people’s liberty (McLachlan 1995). In particular, the policies trammel people’s freedom to take risk without paying an up-front financial cost before they do so. I will call this the *“paternalism objection”*.

The obvious solution to this objection would be to institute a tax and insurance scheme that was not mandatory health. People could simply opt of out paying the risk tax or opt of taking risk insurance if they wished to. Those who wished to opt out could register with the government for some kind of “opt out card” which would state that they did not need to pay tax or purchase insurance.

Adopting an opt-out scheme would certainly be feasible. It would also have the obvious advantage that people would be free to choose which type of cost they wished to bear – i.e. the cost of paying an up-front fee or the (potential) cost of having to pay for health care or doing without health care at a later date. Giving them this option would increase their autonomy and it would do so without violating the responsibility-sensitivity of these policies. Indeed, since governments do not usually prevent people from engaging in health-affecting risky behaviour in the first place it might be argued

that they ought not to prevent people from taking the “secondary” risk of not paying tax or taking out insurance cover.<sup>199</sup>

The problem with the opt-put approach is that it would open the door to a number of objections that the tax and insurance policies were supposed to side step – including the inhumanity and dehumanising objections. These objections would raise their head again because some people would almost certainly choose to opt out of the tax and insurance schemes if this was allowed and many of these people would later require health care that they could not afford. If these individuals were then denied access to health care this would mean that the policies would be vulnerable to the inhumanity objection, but if they were provided with health care free of charge the policies would no longer be responsibility-sensitive and a moral hazard problem would be created.

Adopting an opt-out tax or insurance scheme would also introduce a number of other problems. One of these relates to the issue of whether the opt-in/opt-out choice would be a “once in a lifetime” choice or whether people could opt back in if they changed their minds at a later date. Allowing people to opt back in near the end of their lives – or after that had been diagnosed with a disorder caused by their risky behaviour – would not be possible, but in less extreme cases it is not clear whether it would be reasonable to prevent people from opting back in. Enabling people to do so would allow people to make “mistakes” and would give them the chance to change their minds. However, in order to ensure that these individuals did not free-ride on others they would probably have to pay a “late entry” fee – or pay higher taxes or insurance

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<sup>199</sup> As McLachlan (2010) notes, it is particularly paternalistic “*to force people not to take a risk which they may well have chosen to taken namely the risk of becoming unwell and not receiving all the treatment*” which might have returned them to good health.

premiums – if they wanted to enter the scheme after everyone else had joined. This would not be an impossible solution but it would significantly add to the complexity of calculating costs and operating the system.

For these reasons, I do not think that an “opt out” system is feasible. I accept that this means that people’s autonomy will be diminished. I also accept that this particular problem from the perspective of the “expected consequences” defence of cost bearing because this argument was premised on the value of autonomy. However, if we allow people to opt out of paying tax or purchasing insurance the risk tax and the risk insurance policy will not be able to avoid the inhumanity objection and this outcome needs to be avoided at all costs.<sup>200</sup>

The tax and insurance policies are also affected by the objection that I will dub the “*inequity in ability to take risk objection*”. This objection stems from that fact that income and wealth are distributed very unequally in all modern societies and from the fact that risk taxes and risk insurance premiums will be high given the costs of health care. This means that only some people will be able to afford to take certain risks on a regular basis (Wikler 1978; Dietrich 2002). For example, skiing, scuba diving and sky diving are already expensive but if people have to purchase risk insurance or pay risk taxes the total cost will be prohibitive for many people. Very poor people might even

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<sup>200</sup> Policies which require people to bear costs in this way may also be less paternalistic than one might at first imagine. As Brown (2005) argues “*people often accept rules that require them to do things they know they should do precisely because they realise...that left to their own devices they may fail to these things through carelessness or weakness of will*”. This kind of argument does not entirely undermine the paternalism objection, but it does at least take some of the sting out of it.



find it hard to purchase tobacco and alcohol if the tax or insurance rate was set very high.

It might be said that the only reason why some people can afford to take certain risks at the moment is because they partially externalise the cost of health care provision that is needed if they get ill. It might also be argued that the regressive aspect of commodity taxes would be beneficial because it would mean that those at most risk of ill-health and premature death (i.e. people lower down the socio-economic gradient) would take fewer risks. However, given that disparities in income and wealth do not always stem from differences in moral responsibility there is a serious problem here.

One way of solving this problem would be to redistribute resources in such a way that inequalities in income and wealth are fair. If this was done then people's differing ability to take risks would not be unjust. The obvious objection to this solution is that is it never likely to be achieved and, in any case, such a task is well beyond the means of health care professionals and health policy makers. Another option would be to try and ensure a level playing field by providing tax or insurance discounts to people who had less income and wealth. This would have the disadvantage of providing a perverse incentive especially to poorer people who are already more likely to take risks and it would also add yet another level of complexity to the tax and insurance system. As such, I am not entirely sure that this solution would work. However, offering some kind of discount to people who are not morally responsible for not having sufficient money to pay insurance premiums and taxes does seem necessary.

The risk tax and risk insurance policies are also vulnerable to the *inconsistent enforcement objection*. The problem in this case is that although it is relatively easy to enforce a tax or insurance system in relation to certain commodities (e.g. cigarettes, alcohol and food products containing saturated fat, sugar and salt) it is not easy to enforce such systems in relation to other risky health affecting behaviours (e.g. unprotected sexual intercourse, excessive sun exposure and a failure to exercise regularly). McLachlan (1995), for example, argues that although smoking can be “*monitored, quantified and taxed, other relevant behaviours (and the lack of them) cannot*”. Cappelen and Norheim (2005) similarly argue that it is easy to levy taxes on consumable goods, but trying to do so in the case of unprotected sexual intercourse or in the case of a failure to exercise regularly seems nigh on impossible.

In theory, tax inspectors or insurance inspectors could try and check whether people who were sunbathing and taking part in sports had the required insurance documents or had paid the required tax. Indeed, Veatch (1981) argues that some ingenuity could be deployed to “*tax what seems untaxable*” and he gives the example of taxing gasoline to cover injuries associated with road traffic accidents and taxing mountain climbing equipment to cover injuries associated with this activity. However, quite apart from the fact that this would be incredibly intrusive, some activities (especially unprotected sexual intercourse) seem utterly beyond the reach of any tax or insurance inspector no matter how ingenious they are.

One way to deal with this objection would be to exclude certain behaviours from the tax or insurance scheme. This would solve the enforcement objection, but at high cost because it would open the policies to a charge of injustice because people in a

normatively similar situation would be treated differently. In fact, McLachlan (1995), argues that such a policy would be “*unfair, unjust and inequitable*”. However, there is no obvious way around this latter difficulty and so it is necessary to bite this particular bullet.

The final objection that I wish to raise is the “*negligible risk objection*”. Certain behaviours are, as we have seen, very risky. Sky diving, for example, is risky even if every possible precaution is taken. However, other potentially risky behaviours are only risky if people repeat them regularly. For example, smoking one cigarette a month or drinking one pint of beer a week will only increase people’s risk of developing smoking and alcohol related disease by a negligible amount. But if this is the case, why should people who smoke or drink very occasionally have to pay any tax or special insurance premium at all?

Admittedly, people who smoke or drink occasionally won’t pay much tax if they do not consume these products regularly, but it is not clear why they should pay *any* tax – or why they should have to purchase any specific risk insurance. I am sympathetic to this position and agree with Wikler (1978) that the ideal solution would be to “*identify persons taking risks...and charge higher insurance premiums [or taxes]*” accordingly.

However, if we try to make exceptions for those who rarely smoke or drink the risk tax and risk insurance system would become even more complex. For example, it would be necessary to issue “light” smokers and occasional drinkers with a card which would make them exempt from paying taxes or insurance. But it would be

impossible to stop these individuals from actually consuming a lot of cigarettes and alcohol (e.g. by buying small quantities from different shops) and so it is not clear how the system could operate. As such, I think that the bullet presented by the negligible risk objection must also be bitten by anyone who wishes to implement either the risk tax or the risk insurance policy.

#### **7.4.2 Risk tax and risk insurance policies: summary**

I have argued in the previous section that the risk tax and risk insurance policies avoid many of the more serious objections which may be levelled at the denial of access, payment and priority approaches to cost bearing. In particular, they avoid the inhumanity objection, the dehumanising objection, the damage to doctor-patient relationships objection and, in all probability, the rejection by health care professional's objection too. They also partially avoid the luck and costly-resource objection. However, these policies are not a panacea. Indeed, they are vulnerable to objections that do not affect the denial of access, payment and priority approaches to cost bearing. Nonetheless, of all the policies on offer I think that these are the most normatively reasonable and practically feasible.

#### **7.5. Summary of policies & objections**

I have discussed five different cost bearing policy options in this chapter and I have also analysed an array of objections that may be levelled at these various policies. Since many of these objections apply to multiple policies I have included a table below (Figure 7.0) which lists the objections and demonstrates which policies are

affected by them. Where a check mark (✓) is present the claim being made is that the objection does affect the relevant cost bearing policy. Where a cross (X) is present the claim being made is that the objection does not affect the relevant cost bearing policy. Where a check mark and a cross are both present (✓/X) the claim being made is that the objection partially affects the cost bearing policy in question.

**Figure 7.0. Cost Bearing Policies and Objections.**

	<b>Denial of Access</b>	<b>Payment</b>	<b>Lower priority</b>	<b>Risk Tax</b>	<b>Risk Insurance</b>
<b>Costly resources</b>	✓	✓	✓	X	X
<b>Damage to doctor-patient relationship</b>	✓	✓	✓	X	X
<b>Rejection by health care professionals'</b>	✓	✓	✓	X	X
<b>Inaccuracy</b>	✓	✓	✓	✓	✓
<b>Unreliability</b>	✓	✓	✓	✓	✓
<b>Inhumanity</b>	✓	✓	✓	X	X
<b>Dehumanising</b>	✓	✓	✓	X	X
<b>Intrusiveness</b>	✓	✓	✓	✓	✓
<b>Disrespect</b>	✓	✓	✓	✓	✓
<b>Proportionate health care</b>	✓	✓	X	X	X
<b>Changing the goalposts</b>	✓	✓	✓	X	X
<b>Luck</b>	✓	✓	✓	✓/X	✓/X
<b>Comparison</b>	X	X	✓	X	X
<b>Prediction of costs</b>	X	X	X	✓	✓
<b>Paternalism</b>	X	X	X	✓	✓
<b>Inequity in ability to take risk</b>	X	X	X	✓	✓
<b>Inconsistent enforcement</b>	X	X	X	✓	✓
<b>Negligible risk</b>	X	X	X	✓	✓

## 7.6 Further convergence and divergence

I noted at the beginning of this chapter that, in addition to analysing the denial of access, payment, reduced priority, risk tax and risk insurance policies, I would also explain which of these policies can be supported by which of the five normative arguments discussed in the previous chapter. The following table (Figure 8.0) summarises this information. Where a check mark (✓) is present the claim being made is that the cost bearing policy is defensible on the basis of the relevant normative argument. Where a cross (X) is present the claim being made is that the cost bearing policy is not defensible on the basis of the relevant normative argument. Where a cross and a check mark is present (✓ / X) the claim being made is that the policy might be defensible on the basis of the relevant normative argument.

**Figure 8.0. Normative Arguments and Cost Bearing Policies.**

	<b>Desert</b>	<b>Expected Consequences</b>	<b>Rights Harm</b>	<b>Luck egalitarianism</b>	<b>Utilitarianism</b>
<b>Denial of access</b>	X	✓ / X	✓	✓ / X	✓ / X
<b>Payment</b>	X	✓ / X	✓	✓ / X	✓ / X
<b>Reduced Priority</b>	✓	✓ / X	X	X	✓ / X
<b>Risk Tax</b>	✓	✓ / X	✓	✓ / X	✓ / X
<b>Risk Insurance</b>	✓	✓ / X	✓	✓ / X	✓ / X

The first thing to note about this table is that the utilitarian approach could defend all forms of cost-bearing in principle. This is because, in theory, all forms of cost bearing policy outlined above could increase net utility. However, in reality, it is unlikely that

the utilitarian approach would be able to defend the denial of access approach because the harm and suffering caused by this policy would probably not outweigh the deterrent effect that the policy will have. Indeed, of all the policies discussed above, I think that it is the risk tax and risk insurance policies which will increase net utility the most. This is because these policies provide a powerful and immediate (financial) deterrent, but they are also very humane.

The expected consequences approach can also, in theory, defend all forms of cost bearing. This is because the expected consequences argument can defend any policy which people actually expect. For example, if people expect to bear costs by paying risk taxes then this policy will be defensible from the expected consequences approach. I would add, however, that since the expected consequences account is tied very closely to the value of autonomy any policy which will destroy autonomy will be especially frowned upon by those who take this approach. For example, denying access to healthcare may lead to severe disability and premature death and these outcomes will necessarily reduce autonomy (Brown 2005).

The moralistic desert argument can defend the reduced priority, risk tax and risk insurance policies, but not the denial of access and the payment policies. The moralistic desert argument cannot defend the latter policies because it relies on a retributive approach to cost bearing and all retributive accounts are committed to the idea that the cost that is to be borne must be *proportionate* to the nature and degree of harm caused by the immoral act. In other words, “*the punishment must fit the crime*” (Wikler 2002). The problem is that denial of access and the payment approach will cause immense suffering and, in some cases, premature death and such penalties are

disproportionate responses to the moral “crime” of engaging in self harming risky behaviour. As Harris (1985) forcefully argues: *“to choose to let one person rather than another to die on the grounds of some moral defect their behaviour or character is to take upon ourselves the right not simply to punish, but capitally to punish, offenders against morality”*.

The moralistic desert argument has a similar problem with the reduced priority approach, but because the intention in this case is rather different and because the degree of suffering caused will be less than would be the case with the denial of access and payment policy it might be acceptable from the perspective of most moralistic desert theorists. The moralistic desert argument could also be used to defend the risk tax and risk insurance policies because the bearing of “up-front” costs is proportional to the (alleged) intrinsic immorality of self harming behaviour.

I accept that there may be a problem with the “aptness” of these policies from the perspective of the moralistic desert argument. We do not usually punish or sanction or deny people a benefit by making them pay taxes or by making them purchase insurance. The language of “sin taxes” does exist and Yoder (2002) specifically uses this term in his analysis of responsibility policies. However, the language of “sin insurance” is not widely used and it is not clear that anyone would regard an insurance premium as a penalty. Nonetheless, though making people bear costs via taxation or insurance premiums as a form of punishment, sanction or denial of benefit is unconventional, such an approach is not implausible and because such a response is proportionate these are exactly the kinds of penalties that those who defend the moralistic desert argument can, in fact, support.



The rights-harm policy can also defend all of the policies with the exception of the reduced priority policy. The problem with the reduced priority policy is that people would still, eventually, get access to the health care that they needed under this policy and since resources are limited this would mean that people would use health care resources that other people have a right to. Admittedly, in situations where resources were less scarce this would not be a problem, but the rights-harm argument would not apply in that situation anyway. All the other policies, meanwhile, ensure that people bear costs in such a way that scarce resources are not used to provide people with health care when others have need of these resources and a right to access them.

Finally, the luck egalitarian argument is able to defend all forms of policies except for the reduced priority argument. The problem with the reduced priority policy is that people would still get access to resources eventually and this is problematic given that the luck egalitarian account specifies that people who are morally responsible for their risky behaviour (i.e. people who suffer from “option luck”) should not receive resources on the grounds of justice.

Luck egalitarian would, however, divide over the normative viability of the other policies. Luckist luck egalitarians – i.e. those luck egalitarians committed to sharing costs between people who are equally morally responsible for taking similar risks – are unlikely to support either the denial of access or the payment approach because these policies do not allow costs to be shared in this way. But they will support the risk tax and the risk insurance system. On the other hand, non-luckist luck egalitarians

will take the opposite view and will defend the denial of access and the payment approach but will oppose the risk tax and risk insurance policies.

As I have argued previously, I think that the “luckist” luck egalitarian argument is the most sound and so, from my perspective, the best version of the luck egalitarian argument can be relied upon to defend the policies that are, in any case, the most normatively acceptable and practically feasible.

## **7.7 Conclusion**

In this chapter I have discussed five health care policy measures that could be implemented to ensure that people who are morally responsible for their risky health affecting behaviour bear some of the costs of their choices. These policy options, which I have dubbed the “denial of access”, “payment”, “reduced priority”, “risk tax” and “risk insurance” schemes, would all enable governments to ensure that people who are morally responsible bear some of the costs associated with their health affecting choices.

However, I have argued that of the five possible policies the risk tax and risk insurance schemes are the most practically feasible and normatively reasonable options and that the other policy options are open to very serious objections.

Moreover, I have also demonstrated that the risk tax and the risk insurance policies are the only policies which can be supported by all five of the normative arguments discussed in the last chapter – including the most powerful of these arguments (i.e. the luckist version of the luck egalitarian argument). Consequently, I think that policy makers should create and implement risk taxes and/or risk insurance schemes, but should eschew all other forms of cost bearing policies.

## Chapter 8

### Concluding Remarks

*“Use your health, even to the point of wearing it out. That is what it is for.*

*Spend all you have before you die; do not outlive yourself.”*

*– George Bernard Shaw*

### 8.0 General conclusions

In this thesis I have argued that philosophers must analyse the concept of personal responsibility for health and address the specific issue of cost bearing in relation to risky health affecting behaviours as a matter of some urgency. There are four main reasons for this: (a) there is growing evidence that human beings play a central role in determining their own health, (b) a substantial number of citizens support cost bearing policies, (c) the costs of health care are spiralling out of control and (d) a number of health care professionals, policy makers and insurance companies have already started to implement policies which force patients to bear the costs of their choices. As such, millions of people are already being affected by responsibility-sensitive cost bearing policies and, if trends continue, billions more will be affected by the middle of the 21<sup>st</sup> century.

For these reasons I have concentrated my energies on the sub branch of the responsibility for health debate which relates specifically to the question of whether cost bearing policies are normatively acceptable and practically feasible. In the process I have drawn a number of conclusions, the most important of which are as

follows: (a) many people are substantively causally responsible for their ill-health, (b) a significant number of people are substantively morally responsible for their risky health affecting choices, (c) there are strong normative reasons to think that some people should be held consequentially responsible for their risky health choices and (d) the best way to ensure that people bear costs is to require them to pay risk taxes or to purchase risk insurance.<sup>201</sup>

I have not done enough in this thesis to settle the debate about the normative and practical viability of cost bearing policies once and for all. Moreover, I accept that my primary conclusion – viz. that certain forms of cost bearing policies can and should be implemented – rest on a series of highly controversial claims. In particular, the claim that many people are substantially morally responsible for their risky health affecting behaviour is likely to be hotly contested. Likewise, the empirical claim about the degree of behavioural involvement in the aetiology of disease is likely to be disputed by some epidemiologists and many philosophers will take issue with my argument that the “luckist” version of luck egalitarianism is sound.

However, though I have not solved this particular Gordian Knot, I hope that I have provided a useful framework for those who wish to defend – or oppose – cost bearing claims in relation to risky behaviours and I also hope that I provided policy makers with solid reasons to implement certain kinds of cost bearing policies. Before drawing this thesis to an end, however, I wish to say a few words about some further avenues of research that need to be explored in more depth.

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<sup>201</sup> I have also argued that there is a growing democratic mandate for cost bearing policies, especially in relation to what I have called “core cases” of risky health affecting choices.

## 8.1 Further research

One crucial issue which I have not fully addressed in this thesis is how to balance the value of responsibility with other values like need and cost-effectiveness. This is important because even if we accept that there are good normative and practical reasons to think that people ought to bear some of the costs associated with their risky behaviour, the existence of these other values might give us good reasons to oppose cost bearing. I have tried to take some account of these issues in my thesis. For example, my use of the humanitarian, costly-resources and dehumanising objections reflect a plural approach to the issue of cost bearing. However, I have not offered a comprehensive and systematic analysis of how different values might converge or conflict in relation to the issue of cost bearing.

This task needs to be completed because it is neither politically feasible nor morally reasonable to ignore the plurality of values that the citizens of a country hold dear when devising policies which will determine how scarce healthcare resources are distributed within that country.

However, although there is a risk that the specific arguments for responsibility-sensitive cost bearing policies will be weakened when we take into account all the other relevant values, I don't think that this process will lead us to the conclusion that the concept of personal responsibility is unimportant or that cost bearing claims are unsound. Indeed, it is quite possible that the risk tax and risk insurance policies will withstand the test of "plurality" and their legitimacy may even be reinforced when we take other values into account.

Further research also needs to be carried out to explore the possibility of instituting other kinds of “responsibility for health” policies. For example, we need to determine the normative viability and practical feasibility of health policies based on the concept of “collective responsibility” – such as the regulation of the food and drinks industry and the creation of more green areas in urban centres to encourage exercising. Moreover, further work is needed to determine how reasonable it is to create non-cost bearing health policies based on the concept of personal responsibility – such as bonus schemes for those who engage in behaviour which improves health.

As I noted in the earlier chapters, many governments already operate policies designed to reward people for taking steps to look after their health and almost every developed and developing world government has put in place policies designed to regulate the tobacco and alcohol industry (Wikler 1978; Veatch 1980; Schmid 2007). However, although some scholars have begun to provide a practical and normative defence of these kind of policies, further empirical and normative research needs to be carried out to determine whether these policies are defensible and whether they can be properly integrated with the kinds of cost-bearing policies that I have defended in this thesis.

Further research should also be carried out to determine whether other normative arguments can be successfully deployed to defend cost bearing policies. In this thesis I have limited my analysis to five such arguments, but these may represent the tip of the ethical iceberg. In chapter 6 I briefly mentioned that cost bearing might also be defensible on communitarian, libertarian and “common sense” concepts of justice as

well as non-moral forms of the concept of desert and it is possible that some of these arguments could provide an even more powerful defence of cost bearing than I have offered here.

In addition to these more normative kinds of research, further empirical work is needed in relation to the issue of cost bearing. For example, much more research needs to be carried out to better understand the exact degree to which human behaviour causes human ill-health. Likewise, more empirical work needs to be carried out to determine the relative popularity of different cost bearing policies amongst health care professionals and lay people and to determine exactly which normative arguments people actually rely upon. Moreover, it is important to conduct empirical work into the impact that different cost bearing policies actually have on the people who are affected by them.

Finally, further normative and empirical research needs to be carried out to address two very specific issues about the concept of personal responsibility for health and cost bearing. The first involves the possibility of making people bear costs by changing the way biomedical research is conducted and the second relates to the way in which arguments about personal responsibility will be affected by developments in the field of genetics.

In my thesis I have concentrated overwhelmingly on the issue of personal responsibility in relation to clinical medicine and public policy and, as a result, I have entirely neglected the issue of biomedical research and how the concept of personal responsibility and the notion of cost bearing might impact on the way that research is

conducted. Elsewhere, I have started to address these questions and I have suggested that it might be possible to make people bear costs by re-directing bio-medical research away from diseases which people are sometimes substantively causally and morally responsible for (e.g. obesity, primary hypertension and type 2 diabetes) and towards diseases which people are rarely or never causally or morally responsible for (e.g. paediatric, genetic and neurological diseases) (Hooper 2011). The idea, put simply, is that if we adopt such a policy “*fewer medical products would be produced to treat self inflicted diseases and many more would be produced to treat non self inflicted diseases*” and this would ensure that people who took risks would bear costs in a rather novel kind of way (Ibid, p36).

There are, as one might expect, many advantages and disadvantages of adopting such a policy. For example, it would avoid the “damage to the doctor patient relationship” objection entirely, but it would have the obvious disadvantage that people who were not morally responsible for developing “self inflicted” diseases would be affected just as much as those who were partially or fully morally responsible. However, this policy has sufficient *prima facie* advantages to warrant further research and, in any case, we need to think a little more about how the concept of personal responsibility could impact on the world of biomedical research rather than just the world of clinical medicine and public health policy.

The second specific issue that requires further thought is the way in which genetic developments will soon affect what we are medically capable of achieving. This is because many of these developments will affect the scope of claims about causal and moral – and, therefore, consequential – responsibility.



As things stand genetic diseases are usually cited as examples *par excellence* of diseases for which the individual who is affected by them cannot be causally, let alone morally, responsible. This is for the obvious reasons that people who suffer from these diseases are not in any way responsible for the genes that they inherit and, for a long time, there was little that people could do to influence their health if they had inherited an abnormal gene. Moreover, until quite recently, prospective parents have had very little access to genetic screening tests and were thus unable to screen themselves or their embryos and fetuses. As such, although parents have always been, in one sense, causally responsible for the genetic diseases that afflict their children the notion that they were also morally responsible for these diseases has never seemed especially fair or accurate.

However, rapid advances in genetic technologies – both in terms of screening tests and in terms of the treatments available for people suffering from genetic diseases – will soon change this causal and moral landscape in way that will have profound implications for the concept of personal responsibility for health and cost bearing policies.

To begin with, advances in the available genetic and non-genetic treatment of many genetic diseases (such as Cystic Fibrosis) now mean that patients born with “pure” genetic diseases are likely to live well beyond their childhood years. This is a great boon, but it does mean that people born with genetic disease now have more scope for determining how their diseases progresses post diagnosis. For example, if they refuse to comply with treatment or if they choose to take extra risks (e.g. if someone with Cystic Fibrosis decides to smoke) they may be said to be partially causally

responsible for the *development* of their disease and partially morally responsible for their choices to take “extra” risks.

It is also now possible for children and adults to be screened to find out whether they have developed “risky” genes. For example, women can now find out whether they have inherited the abnormal versions of the BRCA gene – which are a known risk factor for breast cancer – and tests are also available to determine whether people have inherited genes which make them more susceptible to diseases such as hypertension. This is potentially revolutionary because it means that people will be given information which will enable them to make lifestyle choices (e.g. avoiding excessive salt if one is at an especially high risk of developing hypertension) or by opting for early screening or preventative surgery.<sup>202</sup>

More contentiously, perhaps, parents in the developed world have increasing access to genetic screening tests which enable them to screen themselves or their embryos or foetuses for deleterious genetic mutations. This is already done where couples are at high risk of creating children with “pure” genetic diseases like Thalassaemia, Sickle Cell Anaemia and Cystic Fibrosis, but this technology is increasingly likely to be offered to prospective parents where the risk is not the creation of a child with a “pure” genetic disease but the creation of a child who may be at risk of developing a “mixed” genetic and environmental disease. For example, prospective parents may soon be able to test themselves or their embryos and foetuses to see if they are at risk

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<sup>202</sup> Some women known to have BRCA genes are already offered regular screening in the UK and elsewhere and some even have their breasts pre-emptively removed even though they may never develop breast cancer (DeNoon 2010).

of having children with genes that might, one day, cause them to develop type 2 diabetes.

What this all means is that claims about causal, moral and consequential responsibility are likely to become more diverse and more common in the very near future because a whole set of diseases that were once beyond the control human behaviour will no longer be so. Moreover, the kinds of issues that will arise will be very complex to deal with. For example, the question of whether parents have to bear costs if they refused screening and then had a child with some kind of genetic condition will create much heated debate and the further question of whether parents have some kind of duty to abort foetuses who are only “at risk” of developing a mixed genetic-environmental disease will be even more frenzied.

As it happens, some philosophers and bioethicists have already realised that these genetic developments will have serious ramifications for the concept of personal responsibility and cost bearing. For example, Cappelen, Norheim and Tungoden (2008) have argued that “*developments in genetics may relocate the responsibility cut in an epistemic way by affecting which factors we view as being within or beyond the control of individuals [and by] providing new technologies that may make it possible for individuals to affect factors that were previously beyond individual control*”.<sup>203</sup> Likewise, Kelley (2005) has raised the question of whether society will “*hold parents responsible for knowingly brining a child into the world in a harmed state*”.

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<sup>203</sup> Cappelen and Norheim (2005) also argue that “*as we obtain more genetic information on susceptibility, the understanding of individual responsibility will become even more vital*”.

However, relatively little in-depth research has been carried out to determine the precise normative significance of these genetic developments and how they will impact on the claims we make about causal, moral and consequential responsibility. Thus, there is an urgent need to address this issue before the technological developments which are already upon us start proliferating even further and before policy makers and other stakeholders steal yet another march on bioethicists in their deployment of the concepts of responsibility in relation to genetic diseases.

## **8.2 Final thoughts**

Personal responsibility for health is a complex business and there is much work yet to be done to clarify the extent to which people's health really is in their own hands and how physicians, patients and policy makers should respond to a world where human behaviour is causally responsible for a substantive amount of ill-health. In this thesis I have argued that there are some strong normative reasons to think that people who are substantively morally responsible for their risky health affecting choices ought to bear the costs of their choices and I have argued that the tax and insurance policies are the best way of ensuring that people pay these costs. However, I wish to end this thesis with a warning about the general value of health and with a warning about the perils of placing too much emphasis on risk avoidance in our lives.

I have no doubt that health matters both in an intrinsic and an instrumental sense. However, health is not the most important thing in life and we should be careful of over-valuing it because, if we do that, there is a real danger that we will suffer from what Fitzgerald (1994) has called the "*tyranny of health*". Indeed, as a keen scuba

diver, sometime skier and occasional sky diver, I firmly believe that taking risks is part of what makes life worth living. After all, if we do not face up to our mortality from time to time it is hard to see how we will be able to properly value the life that we have been lucky enough to have the opportunity to live.

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